SECTION 1915(c) WAIVER FORMAT

1. The State of Alabama requests a Medicaid home and community-based services waiver under the authority of section 1915(c) of the Social Security Act. The administrative authority under which this waiver will be operated is contained in Appendix A.

   This is a request for a model waiver.

   a.____ Yes b.__X__ No

   If Yes, the State assures that no more than 200 individuals will be served by this waiver at any one time.

   This waiver is requested for a period of (check one):

   a.__X__ 3 years (initial waiver)

   b.____ 5 years (renewal waiver)

2. This waiver is requested in order to provide home and community-based services to individuals who, but for the provision of such services, would require the following levels (s) of care, the cost of which could be reimbursed under the approved Medicaid State plan:

   a.__X__ Nursing facility (NF)

   b.____ Intermediate care facility for mentally retarded or persons with related conditions (ICF/MR)

   c.____ Hospital

   d.____ NF (served in hospital)

   e.____ ICF/MR (served in hospital)

3. A waiver of section 1902(a)(10)(B) of the Act is requested to target waiver services to one of the select group(s) of individuals who would be otherwise eligible for waiver services:

   a.____ aged (age 65 and older)

   b.__X__ disabled

   c.____ aged and disabled

   d.____ mentally retarded

   e.____ developmentally disabled

   f.____ mentally retarded and developmentally disabled

   g.____ chronically mentally ill

4. A waiver of section 1902(a)(10)(B) of the Act is also requested to impose the following additional targeting restrictions (specify):

   a.____ Waiver services are limited to the following age groups (specify):

   b.__X__Waiver services are limited to individuals with the following disease(s) or condition(s) (specify):

   HIV/AIDS and Related Illnesses

c.____ Waiver services are limited to individuals who are mentally retarded or developmentally disabled, who currently reside in general NFs, but who have been shown, as a result of the Pre-Admission Screening and Annual Resident Review process mandated by P.L. 100-203 to require active treatment at the level of an ICF/MR.

d.____ Other criteria. (Specify):

e.____ Not applicable.

5. Except as specified in item 6 below, an individual must meet the Medicaid eligibility criteria set forth in Appendix C-1 in addition to meeting the targeting criteria in items 2 through 4 of this request.

6. This waiver program includes individuals who are eligible under medically needy groups.

a.____ Yes b.__X__ No

7. A waiver of 1902(a)(10)(C)(i)(III) of the Social Security Act has been requested in order to use institutional income and resource rules for the medically needy.

a.____ Yes b.____ No c.__X__ N/A

8. The State will refuse to offer home and community-based services to any person for whom it can reasonably be expected that the cost of home or community-based services furnished to that individual would exceed the cost of a level of care referred to in item 2 of this request.

a.____ Yes b.__X__ No

9. A waiver of the "statewideness" requirements set forth in section 1902(a)(1) of the Act is requested.

a.____ Yes b.__X__ No

If yes, waiver services will be furnished only to individuals in the following geographic areas or political subdivisions of the State (Specify):

10. A waiver of the amount, duration and scope of services requirements contained in section 1902(a)(10)(B) of the Act is requested, in order that services not otherwise available under the approved Medicaid State plan may be provided to individuals served on the waiver.

11. The State requests that the following home and community-based services, as described and defined in Appendix B.1 of this request, be included under this waiver:

a.____ Case management

b.____ Homemaker

c.____ Home health aide services

d.__X__ Personal care services

e.__X__ Respite care

f.____ Adult day health

g.____ Habilitation

____ Residential habilitation

____ Day habilitation

____ Prevocational services

____ Supported employment services

____ Educational services

h.____ Environmental accessibility adaptations

i.__X__ Skilled nursing

j.____ Transportation

k.____ Specialized medical equipment and supplies

l.____ Chore services

m.____ Personal Emergency Response Systems

n.__X__Companion services

o.____ Private duty nursing

p.____ Family training

q.____ Attendant care

r.____ Adult Residential Care

____ Adult foster care

____ Assisted living

s.____ Extended State plan services (Check all that apply):

____ Physician services

____ Home health care services

____ Physical therapy services

____ Occupational therapy services

____ Speech, hearing and language services

____ Prescribed drugs

____ Other (specify):

t.____ Other services (specify):

u.____ The following services will be provided to individuals with chronic mental illness:

____Day treatment/Partial hospitalization

____ Psychosocial rehabilitation

____Clinic services (whether or not furnished in a facility)

12. The state assures that adequate standards exist for each provider of services under the waiver. The State further assures that all provider standards will be met.

13. An individual written plan of care will be developed by qualified individuals for each individual under this waiver. This plan of care will describe the medical and other services (regardless of funding source) to be furnished, their frequency, and the type of provider who will furnish each. All services will be furnished pursuant to a written plan of care. The plan of care will be subject to the approval of the Medicaid Agency. FFP will not be claimed for waiver services furnished prior to the development of the plan of care. FFP will not be claimed for waiver services which are not included in the individual written plan of care.

14. Waiver services will not be furnished to individuals who are inpatients of a hospital, NF, or ICF/MR.

15. FFP will not be claimed in expenditures for the cost of room and board, with the following exception(s) (Check all that apply):

a.____ When provided as part of respite care in a facility approved by the State that is not a private residence (hospital, NF, foster home, or community residential facility).

b.____ Meals furnished as part of a program of adult day health services.

c.____ When a live-in personal caregiver (who is unrelated to the individual receiving care) provides approved waiver services, a portion of the rent and food that may be reasonably attributed to the caregiver who resides in the same household with the waiver recipient. FFP for rent and food for a live-in caregiver is not available if the recipient lives in the caregiver's home, or in a residence that is owned or leased by the provider of Medicaid services. An explanation of the method by which room and board costs are computed is included in Appendix G-3.

For purposes of this provision, "board" means 3 meals a day, or any other full nutritional regimen.

16. The Medicaid Agency provides the following assurances to HCFA:

a. Necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. Those safeguards include:

1. Adequate standards for all types of providers that furnish services under the waiver (see Appendix B);

2. Assurance that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that are provided under the waiver (see Appendix B). The State assures that these requirements will be met on the date that the services are furnished; and

3. Assurance that all facilities covered by section 1616(e) of the Social Security Act, in which home and community-based services will be provided, are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.

b. The agency will provide for an evaluation (and periodic reevaluations, at least annually) of the need for a level of care indicated in item 2 of this request, when there is a reasonable indication that individuals might need such services in the near future (one month or less), but for the availability of home and community-based services. The requirements for such evaluations and reevaluations are detailed in Appendix D.

c. When an individual is determined to be likely to require a level of care indicated in item 2 of this request, and is included in the targeting criteria included in items 3 and 4 of this request, the individual or his or her legal representative will be:

1. Informed of any feasible alternatives under the waiver; and

2. Given the choice of either institutional or home and community-based services.

d. The agency will provide an opportunity for a fair hearing, under 42 CFR Part 431, subpart E, to persons who are not given the choice of home or community-based services as an alternative to institutional care indicated in item 2 of this request, or who are denied the service(s) of their choice, or the provider(s) of their choice.

e. The average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures for the level(s) of care indicated in item 2 of this request under the State plan that would have been made in that fiscal year had the waiver not been granted.

f. The agency's actual total expenditure for home and community-based and other Medicaid services under the waiver and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred by the State's Medicaid program for these individuals in the institutional setting(s) indicated in item 2 of this request in the absence of the waiver.

g. Absent the waiver, persons served in the waiver would receive the appropriate type of Medicaid-funded institutional care that they require, as indicated in item 2 of this request.

h. The agency will provide HCFA annually with information on the impact of the waiver on the type, amount and cost of services provided under the State plan and on the health and welfare of the persons served on the waiver. The information will be consistent with a data collection plan designed by HCFA.

i. The agency will assure financial accountability for funds expended for home and community-based services, provide for an independent audit of its waiver program (except as HCFA may otherwise specify for particular waivers), and it will maintain and make available to HHS, the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver, including reports of any independent audits conducted.

The State conducts a single audit in conformance with the Single Audit Act of 1984, P.L. 98-502.

a.__X__ Yes b.____ No

17. The State will provide for an independent assessment of its waiver that evaluates the quality of care provided, access to care, and cost-neutrality The results of the assessment will be submitted to HCFA at least 90 days prior to the expiration of the approved waiver period and cover the first 24 months (new waivers) or 48 months (renewal waivers) of the waiver.

a.____ Yes b.__X__ No

18. The State assures that it will have in place a formal system by which it ensures the health and welfare of the individuals served on the waiver, through monitoring of the quality control procedures described in this waiver document (including Appendices). Monitoring will ensure that all provider standards and health and welfare assurances are continuously met, and that plans of care are periodically reviewed to ensure that the services furnished are consistent with the identified needs of the individuals. Through these procedures, the State will ensure the quality of services furnished under the waiver and the State plan to waiver persons served on the waiver. The State further assures that all problems identified by this monitoring will be addressed in an appropriate and timely manner, consistent with the severity and nature of the deficiencies.

18. An effective date of 5/1/03 is requested.

19. The State contact person for this request is Felecia Barrow, who can be reached by telephone at (334) 242-5040.

20. This document, together with Appendices A through G, and all attachments, constitutes the State's request for a home and community-based services waiver under section 1915(c) of the Social Security Act. The State affirms that it will abide by all terms and conditions set forth in the waiver (including Appendices and Attachments), and certifies that any modifications to the waiver request will be submitted in writing by the State Medicaid Agency. Upon approval by HCFA, this waiver request will serve as the State's authority to provide home and community services to the target group under its Medicaid plan. Any proposed changes to the approved waiver will be formally requested by the State in the form of waiver amendments.

The State assures that all material referenced in this waiver application (including standards, licensure and certification requirements) will be kept on file at the Medicaid Agency.

Signature:
Print Name: Mike Lewis
Title: Commissioner
Date: _____

APPENDIX A - ADMINISTRATION

LINE OF AUTHORITY FOR WAIVER OPERATION

CHECK ONE:

____ The waiver will be operated directly by the Medical Assistance Unit of the Medicaid Agency.

__X__ The waiver will be operated by the Alabama Department of Public Health, a separate agency of the State, under the supervision of the Medicaid Agency. The Medicaid Agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. A copy of the interagency agreement setting forth the authority and arrangements for this policy is on file at the Medicaid Agency.

____ The waiver will be operated by _____, a separate division within the Single State Agency. The Medicaid Agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. A copy of the interagency agreement setting forth the authority and arrangements for this policy is on file at the Medicaid Agency.

APPENDIX B - SERVICES AND STANDARDS

APPENDIX B-1: DEFINITION OF SERVICES

The State requests that the following home and community-based services, as described and defined herein, be included under this waiver. Provider qualifications/standards for each service are set forth in Appendix B-2.

a. ___ Case Management

___ Services which will assist individuals who receive waiver services in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational and other services, regardless of the funding source for the services to which access is gained.

Case managers shall be responsible for ongoing monitoring of the provision of services included in the individual's plan of care.

1.___Yes 2.___No

Case managers shall initiate and oversee the process of assessment and reassessment of the individual's level of care and the review of plans of care at such intervals as are specified in Appendices C & D of this request.

1.___Yes 2.___No

___ Other Service Definition (Specify):

b.___ Homemaker:

___ Services consisting of general household activities (meal preparation and routine household care) provided by a trained homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home. Homemakers shall meet such standards of education and training as are established by the State for the provision of these activities.

___ Other Service Definition (Specify):

c.___ Home Health Aide services:

___ Services defined in 42 CFR 440.70, with the exception that limitations on the amount, duration and scope of such services imposed by the State's approved Medicaid plan shall not be applicable. The amount, duration and scope of these services shall instead be in accordance with the estimates given in Appendix G of this waiver request. Services provided under the waiver shall be in addition to any available under the approved State plan.

___ Other Service Definition (Specify):

d. X Personal care services:

__ Assistance with eating, bathing, dressing, personal hygiene, activities of daily living. This service may include assistance with preparation of meals, but does not include the cost of the meals themselves. When specified in the plan of care, this service may also include such housekeeping chores as bedmaking, dusting and vacuuming, which are incidental to the care furnished, or which are essential to the health and welfare of the individual, rather than the individual's family. Personal care providers must meet State standards for this service.

1. Services provided by family members (Check one):

___ Payment will not be made for personal care services furnished by a member of the individual's family.

X Personal care providers may be members of the individual's family. Payment will not be made for services furnished to a minor by the child's parent (or step-parent), or to an individual by that person's spouse.

Justification attached. (Check one):

X Family members who provide personal care services must meet the same standards as providers who are unrelated to the individual.

___ Standards for family members providing personal care services differ from those for other providers of this service. The different standards are indicated in Appendix B-2.

2. Supervision of personal care providers will be furnished by (Check all that apply):

_X_ A registered nurse, licensed to practice nursing in the State.

___ A licensed practical or vocational nurse, under the supervision of a registered nurse, as provided under State law.

___ Case managers

___ Other (Specify):

3. Frequency or intensity of supervision (Check one):

___ As indicated in the plan of care

___ Other (Specify):

4. Relationship to State plan services (Check one):

___ Personal care services are not provided under the approved State plan.

___ Personal care services are included in the State plan, but with limitations. The waivered service will serve as an extension of the State plan service, in accordance with documentation provided in Appendix G of this waiver request.

___ Personal care services under the State plan differ in service definition or provider type from the services to be offered under the waiver.

_X_ Other service definition (Specify): Please see attached Scope of Service definition

e._X_ Respite care:

___ Services provided to individuals unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care.

___ Other service definition (Specify):

FFP will not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

Respite care will be provided in the following location(s) (Check all that apply):

_X_ Individual's home or place of residence

___ Foster home

___ Medicaid certified Hospital

___ Medicaid certified NF

___ Medicaid certified ICF/MR

___ Group home

___ Licensed respite care facility

___ Other community care residential facility approved by the State that it's not a private residence (Specify type):

_X_ Other service definition (Specify): Please see attached Scope of Service definition

f.___ Adult day health:

___ Services furnished 4 or more hours per day on a regularly scheduled basis, for one or more days per week, in an outpatient setting, encompassing both health and social services needed to ensure the optimal functioning of the individual. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day). Physical, occupational and speech therapies indicated in the individual's plan of care will be furnished as component parts of this service.

Transportation between the individual's place of residence and the adult day health center will be provided as a component part of adult day health services. The cost of this transportation is included in the rate paid to providers of adult day health services. (Check one):

1.___Yes 2.___No

___ Other service definition (Specify):

Qualifications of the providers of adult day health services are contained in Appendix B-2.

g.____ Habilitation:

___ Services designed to assist individuals in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings. This service includes:

___ Residential habilitation: assistance with acquisition, retention, or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a non-institutional setting. Payments for residential habilitation are not made for room and board, the cost of facility maintenance, upkeep and improvement, other than such costs

for modifications or adaptations to a facility required to assure the health and safety of residents, or to meet the requirements of the applicable life safety code. Payment for residential habilitation does not include payments made, directly or indirectly, to members of the individual's immediate family. Payments will not be made for the routine care and supervision which would be expected to be provided by a family or group home provider, or for activities or supervision for which a payment is made by a source other than Medicaid. Documentation which shows that Medicaid payment does not cover these components is attached to Appendix G.

___ Day habilitation: assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills which takes place in a non-residential setting, separate from the home or facility in which the individual resides. Services shall normally be furnished 4 or more hours per day on a regularly scheduled basis, for 1 or more days per week unless provided as an adjunct to other day activities included in an individual's plan of care.

Day habilitation services shall focus on enabling the individual to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies listed in the plan of care. In addition, day habilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings.

___ Prevocational services not available under a program funded under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17)). Services are aimed at preparing an individual for paid or unpaid employment, but are not job-task oriented. Services include teaching such concepts as compliance, attendance, task completion, problem solving and safety. Prevocational services are provided to persons not expected to be able to join the general work force or participate in a transitional sheltered workshop within one year (excluding supported employment programs).

Prevocational services are available only to individuals who have previously been discharged from a SNF, ICF, NF or ICF/MR.

Check one:

___ Individuals will not be compensated for prevocational services.

___ When compensated, individuals are paid at less than 50 percent of the minimum wage.

Activities included in this service are not primarily directed at teaching specific job skills, but at underlying habilitative goals, such as attention span and motor skills. All prevocational services will be reflected in the individual's plan of care as directed to habilitative, rather than explicit employment objectives.

Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142; and

2. The individual has been deinstitutionalized from a SNF, ICF, NF, or ICF/MR at some prior period.

___ Educational services, which consist of special education and related services as defined in sections (15) and (17) of the Individuals with Disabilities Education Act, to the extent to which they are not available under a program funded by IDEA. Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142; and

2. The individual has been deinstitutionalized from a SNF, ICF, NF, or ICF/MR at some prior period.

___ Supported employment services, which consist of paid employment for persons for whom competitive employment at or above the minimum wage is unlikely, and who, because of their disabilities, need intensive ongoing support to perform in a work setting.

Supported employment is conducted in a variety of settings, particularly work sites in which persons without disabilities are employed. Supported employment includes activities needed to sustain paid work by individuals receiving waiver services, including supervision and training. When supported employment services are provided at a work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision and training required by individuals receiving waiver services as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting.

Supported employment services furnished under the waiver are not available under a program funded by either the Rehabilitation Act of 1973 or P.L. 94-142. Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142; and

2. The individual has been deinstitutionalized from a SNF, ICF, NF, or ICF/MR at some prior period.

FFP will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;

2. Payments that are passed through to users of supported employment programs; or

3. Payments for vocational training that is not directly related to an individual's supported employment program.

Transportation will be provided between the individual's place of residence and the site of the habilitation services, or between habilitation sites (in cases where the individual receives habilitation services in more than one place) as a component part of habilitation services. The cost of this transportation is included in the rate paid to providers of the appropriate type of habilitation services.

1.___Yes 2.___No

___ Other service definition (Specify):

The State requests the authority to provide the following additional services, not specified in the statute. The State assures that each service is cost-effective and necessary to prevent institutionalization. The cost neutrality of each service is demonstrated in Appendix G. Qualifications of providers are found in Appendix B-2.

h.___ Environmental accessibility adaptations:

___ Those physical adaptations to the home, required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the individual would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual.

Excluded are those adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations which add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.

___ Other service definition (Specify):

i. X Skilled nursing:

___ Services listed in the plan of care which are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State.

X Other service definition (Specify): Please see attached Scope of Service definition

j. ___ Transportation:

___ Service offered in order to enable individuals served on the waiver to gain access to waiver and other community services, activities and resources, specified by the plan of care. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them. Transportation services under the waiver shall be offered in accordance with the individual's plan of care. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge will be utilized.

___ Other service definition (Specify):

k.___ Specialized Medical Equipment and Supplies:

___ Specialized medical equipment and supplies to include devices, controls, or appliances, specified in the plan of care, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.

This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items which are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design and installation.

___ Other service definition (Specify):

l.___ Chore services:

___ Services needed to maintain the home in a clean, sanitary and safe environment. This service includes heavy household chores such as washing floors, windows and walls, tacking down loose rugs and tiles, moving heavy items of furniture in order to provide safe access and egress. These services will be provided only in cases where neither the individual, nor anyone else in the household, is capable of performing or financially providing for them, and where no other relative, caregiver, landlord, community/volunteer agency, or third party payor is capable of or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service.

___ Other service definition (Specify):

m.___ Personal Emergency Response Systems (PERS)

___ PERS is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals, as specified in Appendix B-2. PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

___ Other service definition (Specify):

n. X Adult companion services:

___ Non-medical care, supervision and socialization, provided to a functionally impaired adult. Companions may assist or supervise the individual with such tasks as meal preparation, laundry and shopping, but do not perform these activities as discrete services. The provision of companion services does not entail hands-on nursing care. Providers may also perform light housekeeping tasks which are incidental to the care and supervision of the individual. This service is provided in accordance with a therapeutic goal in the plan of care, and is not purely diversional in nature.

__X__ Other service definition (Specify): Please see attached Scope of Service definition

o.____ Private duty nursing:

___ Individual and continuous care (in contrast to part time or intermittent care) provided by licensed nurses within the scope of State law. These services are provided to an individual at home.

___ Other service definition (Specify):

p.____ Family training:

___ Training and counseling services for the families of individuals served on this waiver. For purposes of this service, "family" is defined as the persons who live with or provide care to a person served on the waiver, and may include a parent, spouse, children, relatives, foster family, or in-laws. "Family" does not include individuals who are employed to care for the consumer. Training includes instruction about treatment regimens and use of equipment specified in the plan of care, and shall include updates as necessary to safely maintain the individual at home. All family training must be included in the individual's written plan of care.

___ Other service definition (Specify):

q.___ Attendant care services:

___ Hands-on care, of both a supportive and health-related nature, specific to the needs of a medically stable, physically handicapped individual. Supportive services are those which substitute for the absence, loss, diminution, or impairment of a physical or cognitive function. This service may include skilled or nursing care to the extent permitted by State law. Housekeeping activities which are incidental to the performance of care may also be furnished as part of this activity.

Supervision (Check all that apply):

___ Supervision will be provided by a Registered Nurse, licensed to practice in the State. The frequency and intensity of supervision will be specified in the individual's written plan of care.

___ Supervision may be furnished directly by the individual, when the person has been trained to perform this function, and when the safety and efficacy of consumer-provided supervision has been certified in writing by a registered nurse or otherwise as provided in State law. This certification must be based on direct observation of the consumer and the specific attendant care provider, during the actual provision of care. Documentation of this certification will be maintained in the consumer's individual plan of care.

___ Other supervisory arrangements (Specify):

___ Other service definition (Specify):

r.___ Adult Residential Care (Check all that apply):

___ Adult foster care: Personal care services, homemaker, chore, attendant care and companion services medication oversight (to the extent permitted under State law) provided in a licensed (where applicable) private home by a principal care provider who lives in the home. Adult foster care is furnished to adults who receive these services in conjunction with residing in the home. The total number of individuals (including persons served in the waiver) living in the home, who are unrelated to the principal care provider, cannot exceed__). Separate payment will not be made for homemaker or chore services furnished to an individual receiving adult foster care services, since these services are integral to and inherent in the provision of adult foster care services.

___ Assisted living: Personal care services, homemaker, chore, attendant care, companion services, medication oversight (to the extent permitted under State law), therapeutic social and recreational programming, provided in a home-like environment in a licensed (where applicable) community care facility, in conjunction with residing in the facility. This service includes 24 hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security. Other individuals or agencies may also furnish care directly, or under arrangement with the community care facility, but the care provided by these other entities supplements that provided by the community care facility and does not supplant it.

Personalized care is furnished to individuals who reside in their own living units (which may include dually occupied units when both occupants consent to the arrangement) which may or may not include kitchenette and/or living rooms and which contain bedrooms and toilet facilities. The consumer has a right to privacy. Living units may be locked at the discretion of the consumer, except when a physician or mental health professional has certified in writing that the consumer is sufficiently cognitively impaired as to be a danger to self or others if given the opportunity to lock the door. (This requirement does not apply where it conflicts with fire code.) Each living unit is separate and distinct from each other. The facility must have a central dining room, living room or parlor, and common activity center(s) (which may also serve as living rooms or dining rooms). The consumer retains the right to assume risk, tempered only by the individual's ability to assume responsibility for that risk. Care must be furnished in a way which fosters the independence of each consumer to facilitate aging in place. Routines of care provision and service delivery must be consumer-driven to the maximum extent possible, and treat each person with dignity and respect.

Assisted living services may also include (Check all that apply):

___ Home health care

___ Physical therapy

___ Occupational therapy

___ Speech therapy

___ Medication administration

___ Intermittent skilled nursing services

___ Transportation specified in the plan of care

___ Periodic nursing evaluations

___ Other (Specify)

However, nursing and skilled therapy services (except periodic nursing evaluations if specified above) are incidental, rather than integral to the provision of assisted living services. Payment will not be made for 24-hour skilled care or supervision. FFP is not available in the cost of room and board furnished in conjunction with residing in an assisted living facility.

___ Other service definition (Specify):

Payments for adult residential care services are not made for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement. Payment for adult residential care services does not include payments made, directly or indirectly, to members of the consumer's immediate family. The methodology by which payments are calculated and made is described in Appendix G.

s.___ Other waiver services which are cost-effective and necessary to prevent institutionalization (Specify):

t.___ Extended State plan services:

The following services, available through the approved State plan, will be provided, except that the limitations on amount, duration and scope specified in the plan will not apply. Services will be as defined and described in the approved State plan. The provider qualifications listed in the plan will apply, and are hereby incorporated into this waiver request by reference. These services will be provided under the State plan until the plan limitations have been reached.

Documentation of the extent of services and cost-effectiveness are demonstrated in Appendix G. (Check all that apply):

___ Physician services

___ Home health care services

___ Physical therapy services

___ Occupational therapy services

___ Speech, hearing and language services

___ Prescribed drugs

___ Other State plan services (Specify):

u.___ Services for individuals with chronic mental illness, consisting of (Check one):

___ Day treatment or other partial hospitalization services (Check one):

___ Services that are necessary for the diagnosis or treatment of the individual's mental illness. These services consist of the following elements:

a. individual and group therapy with physicians or psychologists (or other mental health professionals to the extent authorized under State law),

b. occupational therapy, requiring the skills of a qualified occupational therapist,

c. services of social workers, trained psychiatric nurses, and other staff trained to work with individuals with psychiatric illness,

d. drugs and biologicals furnished for therapeutic purposes,

e. individual activity therapies that are not primarily recreational or diversionary,

f. family counseling (the primary purpose of which is treatment of the individual's condition),

g. training and education of the individual (to the extent that training and educational activities are closely and clearly related to the individual's care and treatment), and

h. diagnostic services.

Meals and transportation are excluded from reimbursement under this service. The purpose of this service is to maintain the individual's condition and functional level and to prevent relapse or hospitalization.

___ Other service definition (Specify):

___ Psychosocial rehabilitation services (Check one):

___ Medical or remedial services recommended by a physician or other licensed practitioner under State law, for the maximum reduction of physical or mental disability and the restoration of maximum functional level.

Specific psychosocial rehabilitation services include the following:

a. restoration and maintenance of daily living skills (grooming, personal hygiene, cooking, nutrition, health and mental health education, medication management, money management and maintenance of the living environment);

b. social skills training in appropriate use of community services;

c. development of appropriate personal support networks, therapeutic recreational services (which are focused on therapeutic intervention, rather than diversion); and

d. telephone monitoring and counseling services.

The following are specifically excluded from Medicaid payment for psychosocial rehabilitation services:

a. vocational services,

b. prevocational services,

c. supported employment services, and

d. room and board.

___ Other service definition (Specify):

___ Clinic services (whether or not furnished in a facility) are services defined in 42 CFR 440.90.

Check one:

___ This service is furnished only on the premises of a clinic.

___ Clinic services provided under this waiver may be furnished outside the clinic facility. Services may be furnished in the following locations (Specify):

APPENDIX B-2

PROVIDER QUALIFICATIONS

A. LICENSURE AND CERTIFICATION CHART

The following chart indicates the requirements for the provision of each service under the waiver. Licensure, Regulation, State Administrative Code are referenced by citation. Standards not addressed under uniform State citation are attached.

SERVICE	PROVIDER	LICENSE	CERTIFICATION	OTHER STANDARD
Personal Care	Approved Home Health Vendor Personal Care Worker	NA	NA	See Minimum Qualifications Attached in Scope of Service Individual pg. 3, sec D2 Agency pg. 13, sec G
Skilled Nursing	Approved Home Health Vendor RN	X	NA	See Minimum Qualifications Attached in Scope of Service Individual pg. 2, sec D Agency pg. 11, sec G
Respite Care	Approved Home Health Vendor Respite Care Worker	NA	NA	See Minimum Qualifications Attached in Scope of Service Individual pg. 4, sec D2, 3 Agency pg. 13, sec G

SERVICE	PROVIDER	LICENSE	CERTIFICATION	OTHER STANDARD
Adult Companion	Approved Home Health Vendor Companion Worker	NA	NA	See Minimum Qualifications Attached in Scope of Service Individual pg. 2, sec D2 Agency pg. 13, sec G

B. ASSURANCE THAT REQUIREMENTS ARE MET

The State assures that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services provided under the waiver.

C. PROVIDER REQUIREMENTS APPLICABLE TO EACH SERVICE

For each service for which standards other than, or in addition to State licensure or certification must be met by providers, the applicable educational, professional, or other standards for service provision or for service providers are attached to this Appendix, tabbed and labeled with the name of the service(s) to which they apply.

When the qualifications of providers are set forth in State or Federal law or regulation, it is not necessary to provide copies of the applicable documents. However, the documents must be on file with the State Medicaid Agency, and the licensure and certification chart at the head of this Appendix must contain the precise citation indicating where the standards may be found.

D. FREEDOM OF CHOICE

The State assures that each individual found eligible for the waiver will be given free choice of all qualified providers of each service included in his or her written plan of care.

SCOPE OF SERVICE
FOR
PERSONAL CARE SERVICE
HIV/AIDS WAIVER

A. Definition

Personal Care Service provides assistance with eating, bathing, dressing, caring for personal hygiene, toileting, transferring from bed to chair, ambulation, maintaining continence and other activities of daily living (ADLs). It may include assistance with independent activities of daily living (IADLs) such as meal preparation, but does not include the cost of the meals themselves, using the telephone, and household chores such as, laundry, bed-making, dusting and vacuuming, which are incidental to the assistance provided with ADLs or essential to the health and welfare of the client rather than the client's family.

Personal Care Service is not an entitlement. It is based on the needs of the individual client as reflected in the Plan of Care.

B. Objective

The objective of the Personal Care (PC) Service is to restore, maintain, and promote the health status of clients through home support, health observation, and support of and assistance with activities of daily living.

Personal Care Service is to help waiver clients perform everyday activities when they have a physical, mental, or cognitive impairment that prevents them from carrying out those activities independently.

C. Description of Service to be Provided

1. The unit of service will be one (1) hour of direct PC Service provided in the client's residence. The number of units authorized per visit must be stipulated on the Plan of Care and the Service Authorization Form. The amount of time authorized does not include transportation time to and from the client's residence or the Personal Care Worker's break or mealtime.

2. The number of units and service provided to each client is dependent upon the individual client's needs as set forth in the client's Plan of Care established by the Case Manager, if case management is elected by the client, and subject to approval by the Alabama Medicaid Agency (AMA).

   Medicaid will not reimburse for activities performed which are not within the scope of service.

3. PC Service duties include:

   a. Support for activities of daily living, such as,

      - bathing
      - personal grooming
      - personal hygiene
      - meal preparation
      - assisting clients in and out of bed
      - assisting with ambulation
      - toileting and/or activities to maintain continence

   b. Home support that is essential to the health and welfare of the recipient, such as,

      - cleaning
      - laundry
      - home safety

      Home safety includes a general awareness of the home's surroundings to ensure that the client is residing in a safe environment. Any concerns with safety issues will be reported to the PCW Supervisor as well as the Case Manager for follow-up.

   c. Reporting observed changes in the client's physical, mental or emotional condition.

   d. Reminding clients to take medication.

   e. Accompanying the client to necessary medical appointments, grocery shopping, and obtaining prescription medications. The PCW is not allowed to transport clients, only to accompany them.

Note: Under no circumstances should any type of skilled medical or nursing service be performed by the PCW.

D. Staffing

The DSP must provide all of the following staff positions through employment or subcontractual arrangements.

PC Supervisors and PC Workers must be qualified, trained, and employed by a Medicare/Medicaid certified Home Health Agency or other health care agencies approved by the Commissioner of the Alabama Medicaid Agency.

1. Personal Care (P/C) Supervisors must be a licensed nurse(s) who meet the following requirements:

   a. Have references which will be verified thoroughly and documented in the Direct Service Provider personnel file. (References may include criminal background checks, previous employers, and/or aide register.)

   b. Be a Registered Nurse (RN) or Licensed Practical Nurse (LPN) who is currently licensed by the Alabama State Board of Nursing to practice nursing.

   c. Have at least two (2) years experience as an RN or LPN in public health, hospital, or long term care nursing.

   d. Have the ability to evaluate the Personal Care Worker (PC Worker) in terms of his/her ability to carry out assigned duties and to relate to the client.

   e. Have the ability to coordinate or provide orientation and in-service training to PC Workers on either an individual basis or in a group setting.

   f. Have the ability to provide appropriate follow-up regarding a client/caregiver and/or Case Managers dissatisfaction, complaints or grievances regarding the provision of PC Service.

   g. Submit to a program for the testing, prevention, and control of tuberculosis annually.

   h. Possess a valid, picture identification.

2. PCWs must meet the following qualifications:

   a. Have references which will be verified thoroughly and documented in the Direct Service Provider personnel file. (References may include criminal background checks, previous employers, and/or aide register.)

   b. Be able to read and write.

   c. Possess a valid, picture identification.

   d. Be able to follow the Plan of Care with minimal supervision.

e. Assist client appropriately with activities of daily living as related to personal care.

f. Complete a probationary period determined by the employer with continued employment contingent on completion of a Personal Care in-service training program. No Medicaid payment will be made for the probationary period.

g. Must submit to a program for the testing, prevention, and control of tuberculosis annually.

3. Minimum Training Requirements for Personal Care Workers:

The Personal Care training program should stress the physical, emotional and developmental needs of the population served, including the need for respect of the client, his/her privacy, and his/her property. The minimum training requirement must be completed prior to initiation of service with a client. The DSP is responsible for providing/or conducting the training. The Personal Care training program must be approved by the Operating Agency and the Alabama Medicaid Agency. Proof of the training must be recorded in the personnel file.

Individual records will be maintained on each PCW to document that each member of the staff has met the requirements below.

Minimum training requirements must include the following areas:

a. Activities of daily living, such as,

- bathing (sponge, tub)
- personal grooming
- personal hygiene
- meal preparation
- proper transfer technique (assisting clients in and out of bed)
- assistance with ambulation
- toileting
- feeding the client

b. Home support, such as,

- cleaning
- laundry
- home safety

c. Recognizing and reporting observations of the client, such as,

- physical condition
- mental condition
- emotional condition
- prompting the client of medication regimen

d. Record keeping, such as,

- A service log signed by the client or family member/responsible person and PCW to document what services were provided for the client in relation to the Plan of Care.

- Submitting a written summary to the PCW Supervisor of any problems with client, client's home or family. The Supervisor in return should notify the Case Manager.

e. Communication skills

f. Basic infection control/Universal Standards

g. First aid emergency situations

h. Fire and safety measures

i. Client rights and responsibilities

j. Other areas of training as appropriate or as mandated by Medicaid, or the Operating Agency

4. The DSP will be responsible for providing a minimum of twelve (12) hours of relevant in-service training per calendar year for each PC Worker. In-service training is in addition to PC Worker orientation training. For PC Workers hired during the calendar year, this in-service requirement may be prorated based on date of employment as a PC Worker.

5. Documentation of the training provided shall include topic, date, name and title of trainer, objective of the training, outline of content, length of training, list of trainees and location.

6. Topics for specific in-service training may be mandated by Medicaid or the Operating Agency.

7. In-service training may entail demonstration of providing care to the client. Additional training may be provided as deemed necessary by the DSP. Any self-study training programs must be approved for content and credit hours by Medicaid and the Operating Agency, prior to the planned

training. The DSP shall submit proposed program(s) to the Operating Agency and the Alabama Medicaid Agency at least forty-five (45) days prior to the planned implementation.

8. The DSP must have an ongoing infection control program in effect and training on Universal Standards and an update on infection control shall be included as part of the twelve (12) hours required in-service for all PC Workers each calendar year.

9. The DSP Agency shall maintain records on each employee, which shall include the following:

   a. Application for employment;

   b. Job description;

   c. Record of health (annual tuberculin tests);

   d. Record of pre-employment and in-service training;

      (1) For PC Supervisor validation of required CEUs for licensure will be accepted.

   e. Orientation;

   f. Evaluations;

   g. Supervisory visits;

   h. Copy of photo identification;

   i. Records of all complaints/incidents lodged by the client/family/responsible party and action taken;

   j. Reference contacts;

   k. Other forms as required by state and federal law, including agreements regarding confidentiality.

E. Procedures for Service

1. The Case Manager, if elected by the client, will submit a Service Authorization Form and Plan of Care to the DSP Agency authorizing

Personal Care Service and designating the units, frequency, beginning and ending dates of service, and types of duties in accordance with the individual client's needs.

2. The DSP Agency will initiate PC Service within three (3) working days of receiving the Service Authorization Form in accordance with the following:

   a. Services must **not** be provided prior to the authorized start date as stated on the Service Authorization Form.

   b. The DSP Agency will adhere to the services and schedule as authorized by the Case Manager or the Operating Agency on the Service Authorization Form. No payment will be made for services unless authorized and listed on the Plan of Care.

3. Provision of Service Authorized:

   a. Personal Care Service cannot be provided at the same time other authorized waiver services are being provided.

   b. The Personal Care Worker will not be allowed to provide transportation when he/she is accompanying a client.

   c. Personal Care Workers will maintain a separate service log for each client to document their delivery of services.

      (1) The Personal Care Worker shall complete a service log that will reflect the types of services provided, the number of hours of service, and the date and time of the service.

      (2) The service log must be signed upon each visit by the client, or family member/responsible party and the PC Worker. In the event the client is not physically able to sign and the family member/responsible party is not present to sign, then the Personal Care Worker must document the reason the log was not signed by the client or family member/responsible party.

      (3) The service log will be reviewed and signed by the Personal Care Supervisor at least once every two (2) weeks. Service logs will be retained in the client's file.

      (4) Client visits may be recorded electronically via telephony. Electric documentation will originate from the client's residence as indicated by the phone number at the

residence. A monthly report of phone number exceptions will be maintained with written documentation giving the reason the electronic documentation did not originate at the client's residence, e.g., phone line down, client does not have phone, client staying with relatives. These electronic records may be utilized in place of client signatures.

d. Services provided by relatives or friends may be covered only if relatives or friends meet the qualifications as providers of care and are employed by an approved provider of service. However, providers of service cannot be a parent/legal guardian of a minor or a spouse of the individual receiving services, when the services are those that these persons are legally obligated to provide. There must be strict controls to assure that payment is made to the relatives or friends as providers only in return for Personal Care Services. Additionally, there must be adequate justification as to why the relative or friend is the provider of care and there is documentation in the Case Manager's file showing the lack of other qualified providers in remote areas. The Case Manager, if elected by the client, will conduct an initial assessment of qualified providers in the area of which the client will be informed. The Case Manager must document in the client's file the attempts made to secure other qualified providers before a relative or friend is considered. The Case Manager, along with the DSPs, will review the compiled information in determining the lack of qualified providers for clients living in a remote area.

4. Monitoring of Service:

PC Service must be provided under the supervision of the registered nurse or licensed practical nurse who meets the requirements of D.1. and will:

a. Make the initial visit to the client's residence prior to the start of PC Service for the purpose of reviewing the Plan of Care and providing the client written information regarding advance directives.

The initial visit should be held at the client’s place of residence and should include the Case Manager, if elected by the waiver client, the PC Supervisor, the client, and the caregiver, if feasible. It is advisable to also include the PC Worker in the initial visit.

b. Be immediately accessible by phone during the time PC Service is being provided. Any deviation from this requirement must be prior approved in writing by the Operating Agency and the Alabama Medicaid Agency. If this position becomes vacant the Operating Agency and the Alabama Medicaid Agency must be notified within 24 hours when the position becomes vacant.

c. Provide and document supervision of, training for, and evaluation of PCWs according to the requirements in the approved waiver document.

d. Provide on-site (client's residence) supervision of the PCW at a minimum of every sixty (60) days for each client. Supervisory visits must be documented in the individual client record and a copy placed in the worker's personnel file. Supervisors will conduct on-site supervision more frequently if warranted by complaints or suspicion of substandard performances by the PCW. In the event the on-site supervisory visit cannot be completed in a timely manner due to the client's being inaccessible, the supervisory visit must be completed within five (5) working days following resumption of Personal Care Service. Documentation regarding this action should be in the DSP client record.

e. The DSP must complete the sixty (60) day supervisory review which includes, at a minimum, assurance that the services are being delivered consistent with the Plan of Care and the Service Authorization Form in an appropriate manner, assurance that the client's needs are being met, and a brief statement regarding the client's condition. The summary must be submitted to the Case Manager within ten (l0) calendar days after the sixty (60) day supervisory review. In the event the client is not available during the time the visit would have normally been made, the review must be completed within five (5) working days of the resumption of PC Service.

f. Assist PCWs as necessary as they provide individual Personal Care Service as outlined in the Plan of Care. Any supervision/ assistance given must be documented in the individual client's record.

g. The PC Supervisor must provide direct supervision of each PC Worker with at least one (1) assigned client at a minimum of every six (6) months. Direct supervisory visits must be documented in the PC Worker's personnel record.

(1) Direct supervision may be carried out in conjunction with an on-site supervisory visit.

The PC Supervisor will provide and document the supervision, training, and evaluation of PC Workers according to the requirements in the approved Waiver Document.

5. Missed Visits and Attempted Visits

a. Missed Visits

(1) A missed visit occurs when the client is at home waiting for scheduled services, but the services are not delivered.

(2) The DSP shall have a written policy assuring that when a Personal Care Worker is unavailable, the Supervisor assesses the need for services and makes arrangements for a substitute to provide services as necessary/or reduced by the DSP.

Clients who are designated by the Case Manager as being at-risk should be given first priority when Personal Care Service visits must be temporarily prioritized and/or reduced by the DSP.

(a) If the PCW Supervisor sends a substitute, the substitute will complete the service log and obtain signature from the client or family member/responsible party after finishing duties.

(b) If the PCW Supervisor does not send a substitute, the Supervisor will contact the client and family member/responsible party and inform them of the unavailability of the Personal Care Worker. The Personal Care Worker Supervisor will ensure that the client's health and safety are not at risk.

(3) The DSP will document missed visits in the client's files.

(4) Whenever the DSP determines that services cannot be provided to an at-risk client as authorized, the Case Manager or Operating Agency must be notified by telephone immediately. All missed/attempted visits for one week and the reason for the missed/attempted visit must be reported in writing on the **"Weekly Missed/Attempted Visit Report"** form to the Case Manager on Monday of each week. Any exception to the use of this form must be approved by the Operating Agency and the Alabama Medicaid Agency.

(5) The DSP may **not** bill for missed visits**.**

b. Attempted Visits

(1) An attempted visit occurs when the PCW arrives at the home and is unable to provide services because the client is not at home or refuses services.

(2) If an attempted visit occurs:

(a) The DSP may **not** bill for the attempted visits.

(b) The Supervisor will contact the client to determine the reason why the client was not present or why services were refused. Documentation of this

discussion must be in the client's file.

(c) The DSP will notify the Case Manager or the Operating Agency promptly whenever an attempted visit occurs.

(d) The DSP Agency shall furnish to the Operating Agency and the Alabama Medicaid Agency the daily hours of operation.

6. Changes in Services

a. The DSP will notify the Case Manager or Operating Agency within one (1) working day of the following changes:

(1) Client's condition and/or circumstances have changed and the Plan of Care no longer meets the client's needs:

(2) Client does not appear to need Personal Care Service;

(3) Client dies or moves out of the service area;

(4) Client indicates Personal Care Service is not wanted; and,

(5) Client loses Medicaid financial eligibility;

(6) When services can no longer be provided.

b. The Case Manager or Operating Agency will notify the DSP immediately if a client becomes medically or financially ineligible for waiver services.

c. If the DSP identifies additional duties that may be beneficial to the client's care, but are not specified on the Plan of Care, the DSP shall contact the Case Manager or Operating Agency to discuss having these duties added.

(1) The Case Manager or Operating Agency will review the DSP's request to modify services and respond within one (1) working day of the request.

(2) The Case Manager or Operating Agency will approve any modification of duties to be performed by the PCW and re-issue the Service Authorization Form accordingly.

(3) Documentation of any change in a Plan of Care will be maintained in the client's file.

(a) If the total number of hours of service is changed, a new Service Authorization Form is required from the Case Manager or Operating Agency.

(b) If the types or times of services are changed, a new Service Authorization Form is required from the Case Manager or Operating Agency.

(c) If an individual declines PC Service or has become ineligible for services, a Service Authorization Form for termination is required from the Case Manager or Operating Agency.

7. Documentation and Record-Keeping

a. The DSP shall maintain a record keeping system for each client that documents the units of service delivered based on the Service Authorization Form. The client's file shall be made available to Medicaid, the operating agencies, or other agencies contractually required to review information upon request.

The DSP shall maintain a file on each client, which shall include the following:

(1) A current HCBS application;

(2) Both current and historical Service Authorization Forms specifying units, services, and schedule of Personal Care visits for the client;

(3) Documentation of client specific assistance and/or training rendered by the Supervisor to a Personal Care Worker;

(4) All service logs;

(a) The service log must be reviewed and initialed by the Nurse Supervisor at least once every two (2) weeks.

(5) Records of all missed or attempted visits;

(6) Records of all complaints lodged by clients or family members/responsible parties and any actions taken; and,

(7) Evaluations from all 60 day on-site supervisory visits to the client;

(8) The Service Authorization Form notifying the DSP Agency of termination, if applicable;

(9) Initial visit for in-home services;

(10) Any other notification to Case Manager;

(11) Permission statements to release confidential information, as applicable.

b. The DSP will retain a client's file for at least five (5) years after services are terminated.

c. The DSP Agency shall comply with federal and state confidentiality laws and regulations in regard to client and employee files.

F. Rights, Responsibilities, and Service Complaints

1. The Operating Agency has the responsibility of ensuring that the DSP has fulfilled its duty of properly informing the client of all rights and responsibilities and the manner in which service complaints may be registered.

2. The DSP Agency will inform the client/responsible party of their right to lodge a complaint about the quality of PC Service provided and/or the DSP Agency and will provide information about how to register a complaint with the Case Manager, the Operating Agency and the Alabama Medicaid Agency.

a. Complaints which are made against PCW will be investigated by the DSP Agency and documented in the client's file.

b. All complaints which are to be investigated will be referred to the PCW Supervisor who will take appropriate action. The proposed action to be taken will be forwarded to the Operating Agency and the Alabama Medicaid Agency for review.

c. The PCW Supervisor will take any action necessary and document the action taken in the client's and/or the employee's files, whichever is most appropriate based on the nature of the complaint. This information will be forwarded to the Operating Agency and the Alabama Medicaid Agency for review.

d. The PCW Supervisor will contact the Case Manager, the Operating Agency or the Alabama Medicaid Agency by letter or telephone about any complaint and any corrective action taken.

3. The DSP must maintain documentation of all complaints, follow-up, and corrective action regarding the investigation of those complaints and documentation showing that they have complied with the requirements of this section.

G. Administrative Requirements

In addition to all conditions and requirements contained in the Scope of Services as well as in the contract, the DSP shall be required to adhere to the following stipulations:

1. The DSP Agency shall designate an individual to serve as the agency administrator who shall employ qualified personnel and ensure adequate staff education, in-services training and perform employee evaluations. This does not have to be a full time position; however, the designated administrator must have the authority and responsibility for the direction of the DSP Agency. The DSP Agency shall notify the Operating Agency and the Alabama Medicaid Agency within three (3) working days of a change in the agency administrator, address, phone number or an extended absence of the agency administrator.

2. The DSP will maintain an organizational chart indicating the administrative control and lines of authority for the delegation of responsibility down to the "hands on" client care level staff shall be set forth in writing. This information will be readily accessible to all staff. A copy of this information shall be forwarded to the Alabama Medicaid Agency and the Operating Agency at the time the contract is implemented. Any future revisions or modifications shall be distributed to all staff of the DSP Agency and to the Alabama Medicaid Agency and the Operating Agency.

3. The DSP Agency must have written bylaws or equivalent, which are defined as “a set of rules adopted by the DSP Agency for governing the agency’s operations.” Such bylaws or equivalent shall be readily available to staff of the DSP Agency and shall be provided to the Operating Agency and the Alabama Medicaid Agency upon request.

4. Administrative and supervisory functions shall **not** be delegated to another agency or organization.

5. A list of the members of the DSP's governing body shall be made available to the Operating Agency and the Alabama Medicaid Agency upon request.

6. An annual operating budget, including all actual and anticipated revenue and expenses must be submitted to the Operating Agency and the Alabama Medicaid Agency prior to the signing of the initial contract with the Operating Agency. The budget must comply with Governmental Accepted Accounting Principles (GAAP) guidelines. The DSP Agency must maintain an annual operating budget, which shall be made available to the Operating Agency and the Alabama Medicaid Agency upon request.

7. The DSP Agency shall acquire and maintain during the life of the contract liability insurance to protect all paid and volunteer staff, including board members, from liability incurred while acting on behalf of the agency. Upon

request, the DSP Agency shall furnish a copy of the insurance policy to the Operating Agency and/or the Alabama Medicaid Agency.

8. The DSP Agency shall ensure that key agency staff, including the agency administrator or the DSP Supervisor, be present during compliance review audits conducted by Medicaid, the Operating Agency and/or its agents.

9. The DSP Agency shall maintain an office, which is open during normal business hours and staffed with qualified personnel.

10. The Direct Service Provider (DSP) shall provide its regularly scheduled holidays to the Operating Agency and the Alabama Medicaid Agency. The DSP Agency must not be closed for more than four (4) consecutive days at a time and then only if a holiday falls in conjunction with a weekend. The DSP shall also provide the regular hours of business operation. If a service is needed on a scheduled holiday, the service provider will ensure that the service is rendered.

11. The DSP Agency will maintain a Policy and Procedures Manual to describe how activities will be performed in accordance with the terms of the Operating Agency contract and the Waiver Document. The Policy and Procedure Manual should include the organization's Emergency Plan regarding service delivery.

H. Provider Experience

Providers of Personal Care Service must meet all provider qualifications prior to rendering the Personal Care Service.

SCOPE OF SERVICE
FOR
RESPITE CARE SERVICE
HIV/AIDS WAIVER

A. Definition

Respite Care is provided to individuals unable to care for themselves and is furnished on a short-term basis because of the absence of, or need for relief of those persons normally providing the care.

Skilled or Unskilled Respite is provided for the benefit of the client and to meet client needs in the absence of the primary caregiver(s) rather than to meet the needs of others in the client's household.

Respite Care is not an entitlement. It is based on the needs of the individual client as reflected in the Plan of Care.

B. Objective

The objective of Respite Care is to provide temporary care for clients who live at home and are cared for by their families or other informal support systems. This service will provide temporary, short-term relief for the primary caregiver, and continue the supervision and supportive care necessary to maintain the health and safety of waiver clients. Respite Care is intended to supplement, not replace care provided to waiver clients.

Skilled or Unskilled Respite is provided to clients who have a physical, mental, or cognitive impairment that prevents them from being left alone safely in the absence of the primary caregiver.

C. Description of Service to be Provided

1. The unit of service is one (l) hour of direct Respite Care provided in the client's residence. The amount of time does not include the Respite Care Worker's (RCW) transportation time to or from the client's residence or the Respite Care Worker's break or mealtime.

2. The number of units and services provided to each client is dependent upon the individual client's need as set forth in the client's POC established by the Case Manager if case management is elected by the client. In-home Respite Service may be provided for a period not to exceed 720 hours per waiver year in accordance with the provider contracting period. This limitation applies to skilled and unskilled respite or a combination.

Medicaid will not reimburse for activities performed which are not within the scope of services defined.

3. As implied in the definition, Respite Care is for the relief of the family member or primary caregiver; therefore, there must be a primary caregiver identified for each client that uses the Respite Care Service. The primary caregiver does not have to reside in the residence; however, there must be sufficient documentation to establish that the primary caregiver to be relieved furnishes substantial care of the client.

4. This service must not be used to provide continuous care while the primary caregiver is working or attending school.

5. No payment will be made for services not documented on the Plan of Care and the Service Authorization Form.

6. The type of in-home respite (skilled or unskilled) provided to each client will be dependent upon the individual client's needs as established by the Case Manager, if elected by the client, and set forth in the client's Plan of Care.

   a. Skilled Respite:

      (1) Skilled Respite Service will provide skilled medical or nursing observation and services and will be performed by a Registered Nurse or Licensed Practical Nurse who will perform their duties in compliance with the Nurse Practice Act.

         (a) Orders from the client’s physician(s) are required annually.

         (b) It is the responsibility of the Skilled Respite Provider to obtain such physician orders for the skilled nursing services needed by the client.

      (2) In addition to providing supervision to the client, Skilled Respite may include the following activities:

         (a) Assistance with activities of daily living (ADLs), such as,

            - Bathing, personal hygiene and grooming
            - Dressing
            - Toileting or activities to maintain continence
            - Preparing and serving meals or snacks and providing assistance with eating
            - Transferring
            - Ambulation

(b) Home support that is essential to the health and welfare of the recipient, such as,

- Cleaning
- Laundry
- Assistance with communication
- Home safety

Home safety includes a general awareness of the home's surroundings to ensure that the client is residing in a safe environment. Any concerns with safety issues will be reported to the Case Manager or the Operating Agency for follow-up.

(c) Skilled nursing services as ordered by the client's physician, including administering medications.

(d) Skilled medical observation and monitoring of the client's physical, mental or emotional condition and the reporting of any changes.

(e) Orienting the client to daily events.

b. Unskilled Respite:

(1) Unskilled Respite Services will provide and/or assist with activities of daily living and observations. Unskilled Respite may be performed by a Personal Care or Homemaker Worker.

(2) In addition to providing supervision to the client, Unskilled Respite may include the following activities:

(a) Provision of Personal Care Service, which would ordinarily be performed by the primary caregiver(s) based on the individual needs of the client. (See Scope of Service for Personal Care Service.)

D. Staffing

The DSP must provide all of the following staff positions through employment or sub-contractual arrangements.

1. Skilled Respite Supervisors must meet the following qualifications and requirements:

a. Have references, which will be verified thoroughly and documented in the Direct Service Provider personnel file. (Reference may include criminal background checks, previous employers, and/or aide register.)

b. Be a Registered Nurse (RN) who is currently licensed by the Alabama State Board of Nursing to practice nursing.

c. Have at least two (2) years experience as a Registered Nurse in public health, hospital, home health, or long term care nursing.

d. Have the ability to evaluate the Skilled Respite Worker (SR Worker) in terms of his or her ability to carry out assigned duties and his or her ability to relate to the client.

e. Have the ability to assume responsibility for in-service training for RCWs by individual instruction, group meetings or workshops.

f. Have the ability to provide appropriate follow-up regarding a client/caregiver and/or Case Managers dissatisfaction, complaints or grievances regarding the provision of Respite Care Service.

g. Submit to a program for the testing, prevention, and control of tuberculosis annually.

h. Possess a valid, picture identification.

Unskilled Respite Supervisors must meet the same qualifications as a Personal Care Supervisor depending on the level of care. (See Scope of Service for Personal Care Service.)

2. Skilled Respite Worker - A Licensed Practical Nurse (LPN) or Registered Nurse (RN) who meets the following requirements:

a. Be currently licensed by the State of Alabama to practice nursing.

b. Have at least two years experience in public health, hospital, or long term care nursing.

c. Submit to a program for testing, prevention, and control of tuberculosis, annually.

d. Be able to follow the Plan of Care with minimal supervision unless there is a change in the client's condition.

e. Possess a valid, picture identification.

Minimum Training Requirements for Skilled Respite Care Workers (LPN or RN):

The Direct Service Provider (DSP) must assure Medicaid and the Operating Agency (OA) that the nurse has adequate experience and expertise to perform the skilled services and the care required by the client.

Provide validation of CEUs for licensure.

3. Unskilled Respite Worker - Respite Care Workers who meet the following qualifications and requirements:

   a. Unskilled Respite Workers must meet the same qualifications as a Personal Care Worker and Homemaker Worker dependent upon the level of care. (See Scope of Service for Personal Care Service.)

   Minimum Training Requirements for Unskilled Respite Care Workers:

   Unskilled Respite Workers must meet the same orientation and in-service training requirements as Personal Care Workers, depending upon the level of care. (See Scope of Service for Personal Care Service.)

4. The DSP Agency shall maintain records on each employee, which shall include the following:

   a. Application for employment;

   b. Job description;

   c. Record of health (annual tuberculin tests);

   d. Record of pre-employment and annual in-service training;

      (1) For Skilled Respite Supervisors and Skilled Respite Workers validation of required CEUs for licensure will be accepted for in-service.

   e. Orientation;

   f. Evaluations;

   g. Supervisory visits;

   h. Copy of photo identification;

   i. Records of all complaints/incidents lodged by the client/family/responsible party and action taken;

   j. Reference contacts;

   k. Other forms as required by state and federal law, including agreements regarding confidentiality.

E. Procedure for Service

1. The Case Manager, if elected by the client, will submit a Service Authorization Form and Plan of Care to the DSP Agency authorizing Respite Care designating the units, frequency, beginning date of service, and types of duties in accordance with the individual client's needs. This documentation will be maintained in the client's file.

2. The DSP Agency will initiate Respite Care within three (3) working days of receiving the Service Authorization Form in accordance with the following:

   a. Services must **not** be provided prior to the authorized start date as stated on the Service Authorization Form.

   b. The DSP Agency will adhere to the services and schedule as authorized by the Case Manager on the Service Authorization Form.

   c. No payment will be made for services unless authorized and listed on the Plan of Care.

   c. The DSP will retain a client's file for at least five (5) years after services are terminated.

3. Provision of Service authorized:

   a. Respite Care cannot be provided at the same time other authorized waiver services are being provided.

   b. The Respite Care Worker is not allowed to provide transportation when he/she is accompanying a client.

   c. Services provided by relatives or friends may be covered only if relatives or friends meet the qualifications as providers of care and are employed by an approved provider of service. However, providers of service cannot be a parent/legal guardian of a minor or a spouse of the individual receiving services, when the services are those that these persons are legally obligated to provide. There must be strict controls to assure that payment is made to the relatives or friends as providers only in return for Respite Care Services. Additionally, there must be adequate justification as to why the relative or friend is the provider of care and there is documentation in the Case Manager's or DSP's file showing the lack of other qualified providers in remote areas. The Case Manager, if elected by the client, will conduct an initial assessment of qualified providers in the area of which the client will be informed. The Case Manager must document in the client's file the attempts made to secure other qualified providers before a relative or friend is considered. The Case Manager, along with the DSPs, will review the compiled information in determining the lack of qualified providers for clients living in a remote area.

4. Respite Care Worker will maintain a separate service log for each client to document their delivery of services.

   a. The Respite Care Worker shall complete a service log that will reflect the types of services provided, the number of hours of service, and the date and time of the service.

   b. The service log must be signed upon each visit by the client, or family member/responsible party. In the event the client is not physically able to sign and the family member/responsible party is not present to sign, then the Respite Care Worker must document the reason the log was not signed by the client or family member/responsible party.

   c. The Skilled Respite Worker must fully document the skilled nursing services that were authorized by the client's physician and performed for the client during each visit in which Skilled Respite was provided.

   d. The service logs for Unskilled Respite and the documentation forms for Skilled Respite will be reviewed and signed by the Unskilled or Skilled Respite Supervisor respectively at least once every two (2) weeks. Daily service logs and documentation forms will be retained in the client's file.

   e. Client visits may be recorded electronically via telephony. Electric documentation will originate from the client's residence as indicated by the phone number at the residence. A monthly report of phone number exceptions will be maintained with written documentation giving the reason the electronic documentation did not originate at the client's residence, e.g., phone line down, client does not have phone, client staying with relatives. These electronic records may be utilized in place of client signatures.

   f. The DSP Supervisor should notify the Case Manager or the Operating Agency in writing regarding any report or indication from the DSP Worker regarding a significant change in the client's physical, mental or emotional health. The DSP Supervisor should document such action in the DSP client file.

5. Monitoring of Service:

   Unskilled Respite Care must be provided under the supervision of the Registered Nurse or Licensed Practical Nurse who meets the requirements of D.1.a.-d. and will:

   a. Make the initial visit to the client's residence prior to the start of Respite Care for the purpose of reviewing the Plan of Care and providing the client written information regarding rights and responsibilities and how to register complaints.

b. Be immediately accessible by phone. Any deviation from this requirement must be prior approved in writing by the Operating Agency and the Alabama Medicaid Agency. If this position becomes vacant, the Operating Agency and the Alabama Medicaid Agency must be notified within 24 hours if the position becomes vacant.

c. Provide and document supervision of, training for, and evaluation of Unskilled Respite Care Workers according to the requirements in the approved waiver document.

d. Provide on-site (client's residence) supervision of the Unskilled Respite Care Worker at a minimum of every sixty (60) days for each client. Supervisory visits must be documented in the individual client record and reported to the Operating Agency. Supervisors will conduct on-site supervision more frequently if warranted by complaints or suspicion of substandard performances by the Unskilled Respite Care Worker.

e. Assist Unskilled Respite Care Workers as necessary as they provide individual Respite Service as outlined by the Plan of Care. Any supervision/assistance given must be documented in the individual client's record.

6. Missed Visits and Attempted Visits

a. Missed Visits

(1) A missed visit occurs when the client is at home waiting for scheduled services, but the services are not delivered.

(2) The DSP shall have a written policy assuring that when a Respite Care Worker is unavailable, the RCW Supervisor assesses the need for services and makes arrangements for a substitute to provide services as necessary.

(a) If the RCW Supervisor sends a substitute, the substitute will complete the service log and obtain signature from the client or family member/responsible party after finishing duties.

(b) If the RCW Supervisor does not send a substitute, the Supervisor will contact the client and inform them of the unavailability of the Respite Care Worker. The Respite Care Worker Supervisor will ensure that the client's health and safety are not at risk.

(3) The DSP will document missed visits in the client's files.

(4) Whenever the DSP determines that services cannot be provided as authorized, the Case Manager must be notified by telephone immediately. All missed visits must be reported in writing on the "**Weekly Missed/Attempted Visit Report**" form to the Case Manager on Monday of each week.

(5) The DSP may **not** bill for missed visits.

b. Attempted Visits

(1) An attempted visit occurs when the Respite Care Worker arrives at the home and is unable to provide services because the client is not at home or refuses services.

(2) If an attempted visit occurs:

(a) The DSP may **not** bill for the attempted visits.

(b) The Supervisor will contact the client to determine the reason why the client was not present or why services were refused. Documentation of this discussion must be in the client's file.

(c) The DSP will notify the Case Manager or Operating Agency promptly whenever an attempted visit occurs.

(d) The DSP Agency shall furnish to the Operating Agency and the Alabama Medicaid Agency the daily hours of operation.

7. Changes in Services

a. The DSP will notify the Case Manager or Operating Agency within one (1) working day of the following changes:

(1) Client's condition and/or circumstances have changed and the Plan of Care no longer meets the client's needs;

(2) Client does not appear to need Respite Care;

(3) Client dies or moves out of the service area;

(4) Client indicates Respite Care Service is not wanted; and,

(5) Client loses Medicaid financial eligibility;

(6) When services can no longer be provided.

b. The Case Manager will notify the DSP immediately if a client becomes medically and financially ineligible for waiver services.

The Case Manager must verify Medicaid eligibility on a monthly basis.

c. If the DSP identifies additional duties that would be beneficial to the client's care, but are not specified on the Plan of Care, the DSP shall contact the Case Manager or Operating Agency to discuss having these duties added.

(1) The Case Manager or Operating Agency will review the DSP's request to modify services and respond within one (1) working day of the request.

(2) The Case Manager or Operating Agency will approve any modification of duties to be performed by the Respite Care and re-issue the Service Authorization Form accordingly, if he/she concurs with the request.

(3) Documentation of any changes in a Plan of Care will be maintained in the client's file.

(a) If the total number of hours of service is changed, a new Service Authorization Form is required from the Case Manager or the Operating Agency.

(b) If the types or times of services are changed, a new Service Authorization Form is required from the Case Manager or the Operating Agency.

(c) If an individual declines Respite Care or has become ineligible for services, a Service Authorization Form for termination is required from the Case Manager or Operating Agency.

8. Documentation and Record-Keeping

a. The DSP shall maintain a record keeping system, which documents the units of service delivered based on the Service Authorization Form. The client's file shall be made available to Medicaid, the Operating Agencies, or other agencies contractually required to review information upon request.

The DSP shall maintain a file on each client, which shall include the following:

(1) A current HCBS application;

(2) Both current and historical Service Authorization Forms specifying units, services, and schedule of Respite Care visits for the client;

(3) All service logs;

(a) The service log must be reviewed and initialed by the Nurse Supervisor at least once every two (2) weeks.

(4) Records of all missed or attempted visits;

(5) Records of all complaints lodged by clients or family members/responsible parties and any actions taken;

(6) Evaluations from all 60 day on-site supervisory visits to the client;

(7) The Service Authorization Form notifying the DSP Agency of termination, if applicable;

(8) The name of the primary caregiver.

b. The DSP will retain a client's file for at least five (5) years after services are terminated.

c. The DSP Agency shall comply with federal and state confidentiality laws and regulations in regard to client and employee files.

F. Rights, Responsibilities, and Service Complaints

1. The Operating Agency has the responsibility of ensuring that the DSP has fulfilled its duty of properly informing the client of all rights and responsibilities and the manner in which service complaints may be registered.
2. The DSP Agency will inform the client/responsible party of their right to lodge a complaint about the quality of Respite Care Service provided and will provide information about how to register a complaint with the Case Manager, the Operating Agency and the Alabama Medicaid Agency.

a. Complaints which are made against Respite Care Workers will be investigated by the DSP and documented in the client's file.

b. All complaints to be investigated will be referred to the Respite Care Worker Supervisor who will take appropriate action. The proposed action to be taken will be forwarded to the Operating Agency and the Alabama Medicaid Agency for review.

c. The Respite Care Worker Supervisor will take the actions necessary and document the action taken in the client's and employee's files. This information will be forwarded to the Operating Agency and the Alabama Medicaid Agency for review.

d. The Respite Care Worker Supervisor will contact the Case Manager, Operating Agency or the Alabama Medicaid Agency by letter or telephone about any complaint and any corrective action taken.

3. The DSP must maintain documentation of all complaints, follow-up, and corrective action regarding the investigation of those complaints and documentation showing that they have completed with the requirements of this section.

G. Administrative Requirements

In addition to all conditions and requirements contained in the Scope of Services as well as in the contract, the DSP shall be required to adhere to the following stipulations:

l. The DSP Agency shall designate an individual to serve as the agency administrator. This does not have to be a full time position; however, the designated administrator must have the authority and responsibility for the direction of the DSP Agency. The DSP Agency shall notify the Operating Agency and the Alabama Medicaid Agency within (3) working days of a change in the agency administrator, address, or phone number.

2. The DSP will maintain an organizational chart indicating the administrative control and lines of authority for the delegation of responsibility down to the "hands on" client care level staff shall be set forth in writing. This information will be readily accessible to all staff. A copy of this information shall be forwarded to the Alabama Medicaid Agency and the Operating Agency at the time the contract is implemented. Any future revisions or modifications shall be distributed to all staff of the DSP Agency and to the Alabama Medicaid Agency and the Operating Agency.

3. The DSP Agency must have written bylaws or equivalent, which are defined as “a set of rules adopted by the DSP Agency for governing the agency’s operations.” Such bylaws or equivalent shall be readily available to staff of the DSP Agency and shall be provided to the Operating Agency and the Alabama Medicaid Agency upon request.

4. Administrative and supervisory functions shall not be delegated to another agency or organization.

5. A list of the members of the DSP's governing body shall be made available to the Operating Agency and the Alabama Medicaid Agency upon request.

6. An annual operating budget, including all actual and anticipated revenue and expenses must be submitted to the Operating Agency and the Alabama Medicaid Agency prior to the signing of the initial contract with the Operating Agency. The budget must comply with Governmental Accepted Accounting Principles (GAAP) guidelines. The DSP Agency must maintain an annual operating budget, which shall be made available to the Operating Agency and the Alabama Medicaid Agency upon request.

7. The DSP Agency shall acquire and maintain during the life of the contract liability insurance to protect all paid and volunteer staff, including board members, from liability incurred while acting on behalf of the agency. Upon request, the DSP Agency shall furnish a copy of the insurance policy to the Operating Agency and/or the Alabama Medicaid Agency.

8. The DSP Agency shall ensure that key agency staff, including the agency administrator or the DSP Supervisor, be present during compliance review audits conducted by Medicaid, the Operating Agency and/or its agents.

9. The DSP Agency shall maintain an office, which is open during normal business hours and staffed with qualified personnel.

10. The Direct Service Provider (DSP) shall provide its regularly scheduled holidays to the Operating Agency and the Alabama Medicaid Agency. The DSP Agency must not be closed for more than four (4) consecutive days at a time and then only if a holiday falls in conjunction with a weekend. The DSP shall also provide the regular hours of business operation. If a service is needed on a scheduled holiday, the service provider will ensure that the service is rendered.

11. The DSP Agency will maintain a Policy and Procedures Manual to describe how activities will be performed in accordance with the terms of the Operating Agency contract and the Waiver Document. The Policy and Procedure Manual should include the organization's Emergency Plan regarding service delivery.

H. Provider Experience

Providers of Respite Care must meet all provider qualifications prior to rendering the Respite Care Service.

SCOPE OF SERVICES
FOR
SKILLED NURSING
HIV/AIDS WAIVER

A. Definition

The Skilled Nursing Service is a service which provides skilled medical observation and nursing services performed by a Registered Nurse or Licensed Practical Nurse who will perform their duties in compliance with the Nurse Practice Act and the Alabama State Board of Nursing. Skilled nursing under the waiver will not duplicate skilled nursing under the mandatory home health benefit in the State Plan. If a waiver client meets the criteria to receive the home health benefits, home health should be utilized first and exhausted before Skilled Nursing under the waiver is utilized.

Skilled Nursing Services are not an entitlement. They are based on the needs of the individual client as reflected in the plan of care.

B. Objective

The objective of the Skilled Nursing Service is to provide skilled medical monitoring, direct care, and intervention for the individual with HIV/AIDS to maintain him/her through home support. This service is necessary to avoid institutionalization.

Medicaid will not reimburse for activities performed which are not within the scope of services defined.

C. Description of Service to be Provided

1. The unit of service is one (1) hour of direct skilled nursing care provided in the client's home. The number of units authorized per visit must be stipulated on the Plan of Care (POC) and Service Authorization Form. The amount of time authorized does not include transportation time to and from the client's residence or the skilled nursing break or mealtime.

2. The number of units and services provided to each client is dependent upon the individual client’s need as set forth in the client’s POC established by the Case Manager if case management is elected by the client, and is subject to approval by the Alabama Medicaid Agency (AMA).

3. Skilled Nursing Service duties include:

   (a) Administering medications and treatments prescribed by a licensed or otherwise legally authorized physician or dentist.

   (b) Additional acts requiring appropriate education and training designed to maintain access to a level of health care for the consumer may be performed under emergency or other conditions, which are recognized by the nursing and medical professions as proper to be performed by a registered nurse.

4. The Skilled Nursing Service provider will provide skilled services as ordered by the physician, will evaluate effectiveness of these services, and report changes in conditions as warranted.

D. Staffing

The DSP must provide all of the following through employment or sub-contractual agreements.

1. A licensed practical nurse (LPN) or registered nurse (RN) who meets the following requirements:

   a. Is currently licensed by the Alabama State Board of Nursing to practice nursing.

   b. Has at least two (2) years experience in public health, hospital, home health or long term care nursing.

   c. Must submit to a program for the testing, prevention, and control of tuberculosis, annually.

   d. Skilled Nursing Services provided by an LPN requires supervision by a licensed RN.

2. Minimum training requirements for Licensed Practical Nurses and Registered Nurses:

   a. The Direct Service Provider (DSP) assures the Operating Agency and the Alabama Medicaid Agency that the nurse has adequate experience and expertise to perform the skilled services ordered by the physician.

   b. The DSP will provide for a minimum of six (6) hours of relevant in-service training per year based upon the date of employment for each nurse.

3. Skilled Nursing Service Supervisors' Qualifications – See Section D.1 a.-c. In addition, Skilled Nursing Supervisors must:

   a. Have the ability to evaluate the Skilled Nurse in terms of his/her ability to carry out assigned duties and relate to the client;

   b. Have the ability to coordinate or provide orientation and in-service training to the Skilled Nurse on either an individual basis or in a group setting; and

   c. Have the ability to provide appropriate follow-up regarding a client/caregiver and/or Case Managers' dissatisfaction, complaints or grievances regarding the provision of Skilled Nursing Services.

E. Procedures for Service

1. The DSP will obtain the initial physician's order for skilled nursing. A copy will be sent to the Case Manager, if the Case Management service has been elected by the client, to be placed in the client's file. Written orders are preferable, however, in some situations the nurse may accept a verbal order provided the nurse obtains the physician's signature within two (2) working days from receipt of the verbal order.

2. The Case Manager will authorize and submit a Service Authorization Form to the DSP Agency authorizing Skilled Nursing Services and designating the units, frequency, duration, and types of duties in accordance with the individual client's needs. This documentation will be maintained in the client's file.

3. The DSP Agency will initiate skilled nursing within three (3) working days of receipt of the Service Authorization Form in accordance with the following:

   a. Services must not be provided prior to the authorized start date as stated on the Service Authorization Form.

   b. The DSP Agency will adhere to the services and schedules authorized by the Case Manager on the Service Authorization Form. No payment will be made for services unless authorized on the Service Authorization Form and listed on the POC.

4. The DSP of Skilled Nursing Services must send the physician's treatment plan to the Case Manager, which includes treatment goals, after completion of the first skilled nursing visit. The information provided here will be used to complete the POC for the waiver client.

5. The DSP Agency may recommend to the Case Manager any changes in the hours, times, or specified duties requested. The Case Manager will review a client's Plan of Care within one (1) working day of the DSP's request to modify the Plan of Care. A change in the Service Authorization Form must

be submitted to the DSP Agency if the Case Manager concurs with the request. If necessary, the DSP will be responsible for procuring the skilled nursing orders from the physician.

6. A record keeping system will be maintained which establishes an eligible client profile in support of units of Skilled Nursing. A service log will reflect the services provided by the RN or LPN and the time expended for this service.

7. An individual client record must be maintained by the Case Manager and the DSP. The DSP will maintain the individual client record if the client does not elect the Case Management service. The DSP will retain a client's file for at least five (5) years after services are terminated.

8. Each client under the waiver must provide the name of a designated person(s) and telephone number(s) to the Case Manager or the DSP Agency to ensure the maintenance of seven (7) day, twenty-four (24) hour a day client accessibility. This information will be maintained in the client's record.

9. The DSP of Skilled Nursing Services must develop and maintain a Policy and Procedure Manual approved by the Operating Agency and the Alabama Medicaid Agency which describes how it will perform its activities in accordance with the terms of the contract.

10. The Case Manager will notify the DSP immediately if a client becomes medically ineligible for waiver services. The Case Manager will verify Medicaid eligibility on a monthly basis.

11. Provision of Service authorized:

    a. Skilled Nursing services cannot be provided at the same time other authorized waiver services are being provided.

    b. Services provided by relatives or friends may be covered only if relatives or friends meet the qualifications as providers of care and are employed by an approved provider of service. However, providers of service cannot be a parent/legal guardian of a minor or a spouse of the individual receiving services, when the services are those that these persons are legally obligated to provide. There must be strict controls to assure that payment is made to the relatives or friends as providers only in return for Skilled Nursing Services. Additionally, there must be adequate justification as to why the relative or friend is the provider of care and there is documentation in the Case Manager's file showing the lack of other qualified providers in remote areas. The Case Manager, if elected by the client, will conduct an initial assessment of qualified providers in the area of which the client will be informed. The Case Manager must document in the client's file the attempts made to secure other qualified providers before a relative or friend is considered. The Case Manager, along with

the DSPs, will review the compiled information in determining the lack of qualified providers for clients living in a remote area.

c. The Skilled Nurse is not allowed to provide transportation when he/she is accompanying a client. The RN/LPN may accompany the client, if necessary, to medical appointments. Or, in emergency situations, transport a client to the hospital emergency department via ambulance.

d. The Skilled Nurse will maintain a service log, as well as nurses' notes to document their delivery of services.

(1) The Skilled Nurse shall complete a service log that will reflect the types of services provided, the number of hours of service and the date and time of the service. The nurses' notes should reflect the provision of service and the observed condition of the client.

(2) The service log must be signed upon each visit, by the client or family member/responsible party. In the event the client is not physically able to sign and the family member/responsible party is not present to sign, then the Skilled Nurse must document the reason the log was not signed by the client or family member/responsible party.

(3) Client visits may be recorded electronically via telephony. Electric documentation will originate from the client's residence as indicated by the phone number at the residence. A monthly report of phone number exceptions will be maintained with written documentation giving the reason the electronic documentation did not originate at the client's residence, e.g., phone line down, client does not have phone, client staying with relatives. These electronic records may be utilized in place of client signatures.

12. Monitoring of Service

The Skilled Nursing Service Supervisor will visit the home of clients to monitor services provided by a licensed LPN.

a. The Skilled Nursing Service Supervisor will provide on-site supervision at a minimum of every 60 days for each client. Supervisors will conduct on-site supervision more frequently if warranted by complaints or suspicion of substandard performance by the LPN.

b. Each supervisory visit conducted will be documented in the client's file. The Skilled Nursing Service Supervisor's report of the on-site visits will include, at a minimum:

1) Documentation that services are being delivered consistent with the Plan of Care;

2) Documentation that the client's needs are being met;

3) Reference to any complaints which the client or family member/responsible party has lodged and action taken; and

4) A brief statement regarding any changes in the client's skilled nursing service needs.

c. The Supervisor will provide skilled nursing assistance to the LPN as necessary based on the outlined POC. Any supervision/assistance given must be documented in the individual client record.

d. Skilled Nursing Service Supervisors will be immediately accessible by phone. Any deviation from this requirement must be prior approved in writing by the Operating Agency and the Alabama Medicaid Agency. If this position becomes vacant, the Operating Agency and the Alabama Medicaid Agency must be notified within 24 hours when the position becomes vacant.

13. Missed Visits, and Attempted Visits

a. Missed Visits

1) A missed visit occurs when the client is at home waiting for scheduled services, but the services are not delivered.

2) The DSP shall have a written policy assuring that when a Skilled Nurse is unavailable the Supervisor will assess the need for services and make arrangements for a substitute RN or LPN to provide services as necessary.

(a) If the supervisor sends a substitute RN or LPN, the substitute will complete the service log and obtain signature or telephone authorization from the client or family member/responsible party after completion of duties.

(b) If the Supervisor is not able to send a substitute RN or LPN, the Supervisor will contact the client or family member/responsible party and inform them of the unavailability of the Skilled Nurse. The Supervisor must ensure that the client's health and safety is not at risk.

3) The DSP will document missed visits in the client's files.

4) Whenever the DSP determines that services cannot be provided as authorized, the Case Manager must be notified by telephone immediately. All missed visits must be reported in writing on the

Medicaid's "**WEEKLY MISSED VISIT REPORT**" form to the Case Manager on Monday of each week.

5) The DSP may **not** bill for missed visits.

b. Attempted Visits

1) An attempted visit occurs when the Skilled Nurse arrives at the home and is unable to provide services because the client is not at home or refuses services.

2) If an attempted visit occurs:

a) The DSP may **not** bill for the attempted visits.

b) The Skilled Nurse will contact the client to determine the reason why the client was not present or why services were refused. Documentation of this discussion must be in the client's file.

c) The DSP will notify the Case Manager or the Operating Agency promptly whenever an attempted visit occurs.

d) The DSP Agency shall furnish to the Operating Agency and the Alabama Medicaid Agency the daily hours of operation.

14. Changes in Services

a. The nurse will notify the Case Manager or Operating Agency within one (1) working day of the following client changes:

1) Client's condition has changed and the service plan no longer meets the client's needs or the client no longer needs Skilled Nursing Services.

2) Client dies or moves out of the service area.

3) Client no longer wishes to receive the Skilled Nursing Service.

4) Client loses Medicaid financial eligibility.

b. The Case Manager or the Operating Agency will notify the DSP immediately if a client becomes medically ineligible for waiver services.

c. If the DSP identifies additional duties that would be beneficial to the client's care, but are not specified on the Plan of Care, the DSP shall

contact the Case Manager or the Operating Agency to discuss having these duties added.

1) The Case Manager or the Operating Agency will review the DSP's request to modify services and respond within one (1) working day of the request.

2) The Case Manager or the Operating Agency will approve any modification of duties to be performed by the Skilled Nurse and re-issue the Service Authorization Form accordingly.

3) Documentation of any changes in a Plan of Care will be maintained in the client's file.

a) If the total number of hours of service is changed, a new Service Authorization Form is required from the Case Manager or the Operating Agency.

b) If the types or times of services are changed, a new Service Authorization Form is required from the Case Manager or the Operating Agency.

c) If an individual declines the Skilled Nursing service or has become ineligible for services, a Service Authorization Form for termination is required from the Case Manager or the Operating Agency.

15. Documentation and Record-Keeping

a. The DSP shall maintain a record keeping system, which documents the units of service delivered based on the Service Authorization Form. The client's file shall be made available upon request to Medicaid, the operating agencies, or other agencies contractually required to review information upon request.

The DSP shall maintain a file on each client, which shall include the following:

1) The most recent assessment performed, including the plan of care;

2) A current HCBS application;

3) Both current and historical Service Authorization Forms specifying units, services, and schedule of Skilled Nursing visits for the client;

4) All service logs reflecting the services provided by the LPN or RN;

5) All nurses' notes reflecting the provision of services and the observed condition of the client;

6) All service logs and nurses' notes:

(a) Must be reviewed and initialed by the Skilled Nurse Supervisor at least once every two (2) weeks.

7) Records of all missed or attempted visits;

8) Records of all complaints lodged by clients or family members/responsible parties and any actions taken; and

9) Evaluations from all 60 day on-site supervisory visits to the client.

10) The Service Authorization Form notifying the DSP Agency of termination, if applicable.

11) Initial visit for in-home services;

12) Any other notification to Case Manager;

13) Permission statements to release confidential information, as applicable.

b. The DSP will retain a client's file for at least five (5) years after services are terminated.

c. The DSP Agency shall maintain records on each employee, which shall include the following:

1) Each employee's application for employment;

2) Job description;

3) Record of health (annual tuberculin tests);

4) Record of pre-employment and in-service training;

5) Orientation;

6) Evaluations;

7) Work attendance;

8) Supervisory visits;

9) Copy of photo identification;

10) Complaint file/resolutions; and

11) Reference contacts.

d. The DSP Agency shall comply with federal and state confidentiality laws and regulations in regard to client and employee files.

F. Rights, Responsibilities, and Service Complaints

1. The Operating Agency has the responsibility of ensuring that the DSP has fulfilled its duty of properly informing the client of all rights and responsibilities and the manner in which service complaints may be registered.

2. The DSP Agency will inform the client/responsible party of their right to lodge a complaint about the quality of Skilled Nursing Services provided and/or the DSP Agency and will provide information about how to register a complaint with the Case Manager as well as the Alabama Medicaid Agency.

   a. Complaints that are made against nurses will be investigated by the DSP and documented in the client's file.

   b. All complaints to be investigated regarding services provided by the RN/LPN of the DSP Agency will be referred to the Skilled Nursing Service Supervisor who will take appropriate action. The proposed action to be taken will be forwarded to the Operating Agency and the AMA for review.

   c. The Skilled Nursing Service Supervisor and DSP will take actions necessary and document the action taken in the client's and employee's files. This information will be forwarded to the Operating Agency and the AMA for review.

   d. The DSP or Skilled Nursing Service Supervisor will contact the Case Manager, the Operating Agency or the AMA by letter or telephone about any complaint and any corrective action taken.

3. The DSP must maintain documentation showing that they have complied with the requirements of this section.

G. Administrative Requirements

In addition to all conditions and requirements contained in the Scope of Services as well as in the contract, the DSP shall be required to adhere to the following stipulations:

1. The DSP shall designate an individual to serve as the administrator who shall employ qualified personnel and ensure adequate staff education, in-service training, and perform employee evaluations. This does not have to be a full-time

position; however, the designated administrator will have the authority and responsibility for the direction of Skilled Nursing Services for the DSP Agency. The DSP Agency shall notify the operating agencies within three (3) working days in the event of a change in the administrator, address, telephone number, or of an extended absence of the agency administrator.

2. The DSP will maintain an organizational chart indicating the administrative control and lines of authority for the delegation of responsibility to staff providing "hands on" client care and shall be set forth in writing. This information will be readily accessible to all staff. A copy of this shall be forwarded to the Alabama Medicaid Agency and the Operating Agency at the time the contract is implemented. Any future revisions or modifications shall be distributed to all staff of the DSP Agency and to the Alabama Medicaid Agency and the Operating Agency.

3. The DSP Agency must have written bylaws or equivalent which are defined as "a set of rules adopted by the DSP Agency for governing the agency's operations." Such bylaws or equivalent shall be readily available to staff of the DSP Agency and shall be provided to the Operating Agency and the Alabama Medicaid Agency upon request.

4. Administrative and supervisory functions shall **not** be delegated to another organization.

5. A list of the members of the DSP's governing body shall be available to the Operating Agency and the Alabama Medicaid Agency upon request.

6. The DSP will maintain a policy and procedures manual to describe how activities will be performed in accordance with the terms of this contract and include the organization's emergency plan. All policies and procedures shall be kept in the organization's manual which shall be available during office hours for the guidance of the governing body, personnel, and to the operating agencies upon request. The manual is subject to the approval of the Operating Agency and the Alabama Medicaid Agency.

7. The DSP shall acquire and maintain liability insurance during the life of this contract to protect all paid and volunteer staff, including board members, from liability incurred while acting on behalf of the DSP. Upon request, the DSP shall furnish a copy of the insurance policy to the Operating Agency and the Alabama Medicaid Agency.

8. The DSP shall conform to applicable federal, state and local health and safety rules and regulations, and have an on-going program to prevent the spread of infectious diseases among its employees.

9. The DSP shall maintain an office, which will be open during normal business hours and staffed with qualified personnel.

10. An annual operating budget, including all actual and anticipated revenue and expenses must be submitted to the Operating Agency and the Alabama Medicaid Agency prior to the signing of the initial contract with the Operating Agency. The budget must comply with Governmental Accepted Accounting Principles (GAAP) guidelines. The DSP Agency must maintain an annual operating budget which shall be made available to the Operating Agency and the Alabama Medicaid Agency upon request.

11. The Direct Service Provider (DSP) shall provide its regularly scheduled holidays to the Operating Agency and the Alabama Medicaid Agency. The DSP Agency must not be closed for more than four (4) consecutive days at a time and then only if a holiday falls in conjunction with a weekend. The DSP shall also provide the regular hours of business operation. If a service is needed on a scheduled holiday, the service provider will assure that the service is rendered.

H. Provider Experience

Providers of Skilled Nursing Service must meet all provider qualifications prior to rendering the Skilled Nursing Service.

SCOPE OF SERVICE
FOR
COMPANION SERVICE
HIV/AIDS WAIVER

A. Definition

Companion Service is non-medical assistance, observation, supervision and socialization, provided to a functionally impaired adult. Companions may provide limited assistance or supervise the individual with such tasks as activities of daily living, meal preparation, laundry and shopping, but do not perform these activities as discrete services. The Companion may also perform housekeeping tasks which are incidental to the care and supervision of the individual. Companion Service is provided in accordance with a therapeutic goal as stated in the Plan of Care, and is not purely diversional in nature. The therapeutic goal may be related to client safety and/or toward promoting client independence or toward promoting the mental or emotional health of the client.

Companion Service is not an entitlement. It is provided based on the needs of the individual client as reflected in the Plan of Care.

B. Objective

The objective of Companion Service is to provide support and supervision that is focused on safety, non-medical care and socialization for clients participating in the HIV/AIDS Waiver.

C. Description of Service to be Provided

1. The unit of service will be one (1) hour of direct Companion Service provided to the client. The number of units per visit must be indicated on the Plan of Care and the Service Authorization Form. The amount of time authorized does not include the Companion Worker's transportation time to or from the client's home, or the Companion Worker's break or mealtime.

2. The number of units and service provided to each client is dependent upon the individual client's needs as set forth in the client's Plan of Care which is established by the Case Manager, if elected by the client, and subject to approval by the Alabama Medicaid Agency (AMA).

   Medicaid will not reimburse for activities performed which are not within the scope of services defined.

3. Companion Service includes:

   a. Supervision/observation of daily living activities, such as,

      (1) Reminding client to bathe and take care of personal grooming and hygiene;

      (2) Reminding client to take medication;

      (3) Observation/supervision of snack, meal planning and preparation, and/or eating;

      (4) Toileting or maintaining continence.

   b. Accompanying the client to necessary medical appointments, grocery shopping, and obtaining prescription medications. The Companion Worker is not allowed to transport clients, only to accompany them.

   c. Supervision/assistance with laundry.

   d. Performance of housekeeping duties that are essential to the care of the client.

   e. Assist with communication.

   f. Reporting observed changes in the client's physical, mental or emotional condition.

D. Staffing

The DSP must provide all of the following staff positions through employment or sub-contractual arrangements.

1. Companion Worker Supervisors' Qualifications

   All Companion Worker Supervisors will have the following qualifications:

   a. High school diploma or equivalent;

   b. Be able to evaluate Companion Worker in terms of their ability to perform assigned duties and communicate with the individuals;

   c. Be able to assume responsibility for in-service training for Companion Workers by individual instructions, group meetings, or workshops;

   d. Submit to programs for the testing, prevention, and control of tuberculosis annually;

e. Have reference which will be verified thoroughly and documented in the Direct Service Provider personnel file. (References may include criminal background employers, and/or aide register);

f. Have the ability to provide appropriate follow-up regarding a client/caregiver and/or Case Managers dissatisfaction, complaints or grievances regarding the provision of Companion Service;

g. Possess a valid, picture identification.

2. All Companions Workers must meet the following qualifications:

a. Be able to read and write;

b. Submit to programs for the testing, prevention, and control of tuberculosis annually;

c. Have references which will be verified thoroughly and documented in the Direct Service Provider's personnel file (references may include criminal background checks, previous employer and/or aide register);

d. Possess a valid, picture identification;

e. Be able to follow the Plan of Care with minimal supervision unless there is a change in the client's condition.

f. Complete a probationary period determined by the employer with continued employment contingent on completion of the in-service training program. No Medicaid payment will be made for the probationary period.

3. Minimum Training Requirements for Companion Worker

The Companion Worker training program should stress the physical, emotional and developmental needs of the population served, including the need for respect of the client, his/her privacy, and his/her property. The minimum training requirement must be completed prior to initiation of service with a client. The DSP is responsible for providing/or conducting the training. The Companion Worker training program must be approved by the Operating Agency and the Alabama Medicaid Agency. Proof of the training must be recorded in the personnel file.

The Companion Worker must successfully complete orientation training in areas specified below prior to providing Companion Services or have documentation of personal, volunteer, or paid experience in the care of adults, families, and/or the disabled, home management, household duties, preparation of food, and be able to communicate observations verbally and in writing.

a. Meal planning and preparation;

b. Laundry/shopping;

c. Provision of care and supervision including individual safety;

d. First aid in emergency situations;

e. Documentation of services provided per written instructions;

f. Basic infection Control/Universal Standards; and,

g. Fire and safety measures;

h. Assist clients with medications;

i. Communication skills;

j. Client rights;

k. Other areas of training as appropriate or as mandated by Medicaid and/or the Operating Agency.

4. The annual in-service training will be provided by the DSP and is in addition to the training required prior to job placement.

5. All Companion Workers must have at least six (6) hours in-service training annually. For Companion Workers hired during the calendar year, this in-service requirement may be prorated based on date of employment as a Companion Worker.

6. Documentation of the training provided shall include topic, date, name and title of trainer, objective of the training, outline of content, length of training, list of trainees and location.

7. Topics for specific in-service training may be mandated by Medicaid or the Operating Agency.

8. In-service training may entail demonstration of providing care to the client. Additional training may be provided as deemed necessary by the DSP. Any self-study training programs must be approved for content and credit hours by Medicaid and the Operating Agency, prior to the planned training. The DSP shall submit the proposed program(s) to the Operating Agency and the Alabama Medicaid Agency at least forty-five (45) days prior to the planned implementation.

9. The DSP must have an ongoing infection control program in effect and training on Universal Standards and an update on infection control shall be included as part of the six (6) hours required in-service for all Companion Workers each calendar year.

10. The DSP Agency shall maintain records on each employee, which shall include the following:

a. Application for employment;

b. Job description;

c. Record of health (annual tuberculin tests);

d. Record of pre-employment and in-service training;

e. Orientation;

f. Evaluations;

g. Supervisory visits;

h. Copy of photo identification;

i. Reference contacts;

j. Other forms as required by State and Federal law, including agreements regarding confidentiality.

E. Procedure for Service

1. The Case Manager, if elected by the client, will submit a Service Authorization Form and a copy of the Plan of Care to the DSP Agency, authorizing Companion Service and designating the units, frequency, beginning date of service, and types of duties in accordance with the individual client's needs as set forth in the Plan of Care.

2. The DSP Agency will initiate Companion Service within three (3) working days of receiving the Service Authorization Form in accordance with the following:

   a. Services must **not** be provided prior to the authorized start date as stated on the Service Authorization Form:

   b. The DSP Agency will adhere to the services and schedule as authorized by the Case Manager, if case management is elected by the client, on the Service Authorization Form. No payment will be made for services unless authorized and listed on the Plan of Care.

3. Provision of Service Authorized:

   a. Companion Service cannot be provided at the same time as other authorized waiver services are being provided.

   b. Services provided by relatives or friends may be covered only if relatives or friends meet the qualifications as providers of care and are employed by an approved provider of service. However, providers of service cannot be a parent/legal guardian of a minor or a spouse of the

individual receiving services, when the services are those that these persons are legally obligated to provide. There must be strict controls to assure that payment is made to the relatives or friends as providers only in return for Companion Services. Additionally, there must be adequate justification as to why the relative or friend is the provider of care and there is documentation in the Case Manager's file showing the lack of other qualified providers in remote areas. The Case Manager, if elected by the client, will conduct an initial assessment of qualified providers in the area of which the client will be informed. The Case Manager must document in the client's file the attempts made to secure other qualified providers before a relative or friend is considered. The Case Manager, along with the DSPs, will review the compiled information in determining the lack of qualified providers for clients living in a remote area.

c. The Companion Worker is not allowed to provide transportation when he/she is accompanying a client.

4. Companion Workers will maintain a separate service log for each client to document their delivery of services.

a. The Companion Worker shall complete a service log that will reflect the types of services provided, the number of hours of service, and the date and time of the service.

b. The service log must be signed upon each visit by the client, or family member/responsible party and the Companion Worker. In the event the client is not physically able to sign and the family member/ responsible party is not present to sign, then the Companion Worker must document the reason the log was not signed by the client or family member/responsible party.

c. The service log will be reviewed and signed by the Companion Worker Supervisor at least once every two (2) weeks. Service logs will be retained in the client’s file.

d. Client visits may be recorded electronically via telephony. Electric documentation will originate from the client's residence as indicated by the phone number at the residence. A monthly report of phone number exceptions will be maintained with written documentation giving the reason the electronic documentation did not originate at the client's residence, e.g., phone line down, client does not have phone, client staying with relatives. These electronic records may be utilized in place of client signatures.

5. Monitoring of Service

a. The Companion Worker Supervisor will visit the home of clients to monitor services.

(1) The Companion Worker Supervisor will make the initial visit to the client's residence prior to the start of Companion Service for the purpose of reviewing the Plan of Care and discuss with the client the provisions and supervision of the service.

The initial visit should be held at the client's place of residence and should include the Case Manager, if elected by the client, the Companion Supervisor, the client and caregiver if feasible. It is advisable to also include the CompanionWorker in the initial visit.

(2) The Companion Worker Supervisor will provide on-site supervision at the client's place of residence at a minimum of every 90 days for each client. Supervisors will conduct on-site supervision more frequently if warranted by complaints or suspicion of substandard performance by the Companion Worker. Supervisory visits must be documented in the individual client record and a copy placed in the individual's personnel file.

In the event the on-site supervisory visit cannot be completed in a timely manner due to the client's being inaccessible, the supervisory visit must be completed within five (5) working days following resumption of Companion Service. Documentation regarding this action should be in the DSP client file.

(3) Each Companion Worker supervisory visit will be documented in the client's file. The Companion Worker Supervisor's report of the on-site visits will include, at a minimum:

(a) Documentation that services are being delivered consistent with the Plan of Care;

(b) Documentation that the client's needs are being met;

(c) Reference to any complaints which the client or family member/responsible party has lodged and action taken;

(d) A brief statement regarding any changes in the client's Companion Service needs.

(e) The Companion Service Supervisor will provide assistance to Companion Worker as necessary.

(f) Companion Worker Supervisor must be immediately accessible by phone during the time Companion Service is being provided. Any deviation from this requirement must be prior approved in writing by the Operating Agency and the Alabama Medicaid Agency. If this position becomes vacant, the Operating Agency and the Alabama Medicaid Agency must be notified in writing within 24 hours if the position becomes vacant.

(g) The Companion Worker Supervisor must provide direct supervision of each Companion Worker with at least one (1) assigned client at a minimum of every six (6) months. Direct supervisory visits must be documented in the Companion Worker's personnel record.

(i) Direct supervision may be carried out in conjunction with an on-site supervisory visit.

(h) The Companion Worker Supervisor will provide and document the supervision, training, and evaluation of Companion Workers according to the requirements in the approved Waiver Document.

6. Missed Visits, and Attempted Visits

a. Missed Visits

(1) A missed visit occurs when the client is at home waiting for scheduled services, but the services are not delivered.

(2) The DSP shall have a written policy assuring that, when a Companion Worker is unavailable, the Companion Worker Supervisor will assess the need for services and makes arrangements for a substitute to provide services as necessary.

Clients who are designated by the Case Manager or the Operating Agency as being at-risk should be given first priority when Companion Service visits must be temporarily prioritized and/or reduced by the DSP.

(a) If the Companion Worker Supervisor sends a substitute, the substitute will complete the service log and obtain signature from the client or family member/responsible party after finishing duties.

(b) If the Companion Worker Supervisor does not send a substitute, the Companion Worker Supervisor will contact the client or family member/responsible party and inform

them of the unavailability of the Companion Worker. The Companion Worker Supervisor will ensure that the client's health and safety are not at risk.

(3) The DSP will document missed visits in the client's files.

(4) Whenever the DSP determines that services cannot be provided to an at-risk client as authorized, the Case Manager or Operating Agency must be notified by telephone immediately. All missed/attempted visits for one week and the reason for the missed/attempted visit must be reported in writing on the "**Weekly Missed/ Attempted Visit Report**" form to the Case Manager on Monday of each week. Any exception to the use of this form must be approved by the Operating Agency and the Alabama Medicaid Agency.

(5) The DSP may **not** bill for missed visits.

b. Attempted Visits

(1) An attempted visit occurs when the Companion Worker arrives at the home and is unable to provide services because the client is not at home or refuses services.

(2) If an attempted visit occurs:

(a) The DSP may **not** bill for the attempted visits.

(b) The Companion Worker Supervisor will contact the client to determine the reason why the client was not present or why services were refused, and document in the client's file.

(c) The DSP will notify the Case Manager or Operating Agency promptly whenever an attempted visit occurs.

(d) The DSP Agency shall furnish to the Operating Agency and the Alabama Medicaid Agency the daily hours of operation.

7. Changes in Services

a. The DSP will notify the Case Manager or Operating Agency within one (1) working day of the following changes:

(1) Client's condition and/or circumstances have changed and that the Plan of Care no longer meets the client's needs;

(2) Client does not appear to need Companion Service;

(3) Client dies or moves out of the service area;

(4) Client indicates Companion Service is not wanted; and,

(5) Client loses Medicaid financial eligibility;

(6) When services can no longer be provided.

b. The Case Manager or Operating Agency will notify the DSP within one (1) working day if a client becomes ineligible for waiver services.

c. If the DSP identifies additional duties that may be beneficial to the client's care, but are not specified on the Plan of Care, the DSP shall contact the Case Manager to discuss having these duties added.

(1) The Case Manager will review the DSP's request to modify services and respond within one (1) working day of the request.

(2) The Case Manager, if elected by the client, will approve any modification of duties to be performed by the Companion and re-issue the Service Authorization Form accordingly.

(3) Documentation of any changes in a Plan of Care will be maintained in the client's file.

(a) If the total number of hours of service is changed, a new Service Authorization Form is required from the Case Manager.

(b) If the types or times of services are changed, a new Service Authorization Form is required from the Case Manager.

(c) If an individual declines Companion Service or has become ineligible for services, a Service Authorization Form for termination is required from the Case Manager. If case management is not elected by the client, the Service Authorization Form for termination is required from the Operating Agency.

8. Documentation and Record-Keeping

a. The DSP shall maintain a record keeping system for each client that documents the units of service delivered based on the Service Authorization Form. The client's file shall be made available upon request to Medicaid, the administering agencies, or other agencies contractually required to review information.

The DSP shall maintain a file on each client, which shall include the following:

(1) A current HCBS application;

(2) Both current and historical Service Authorization Forms specifying units, services, and schedule of Companion visits for the client;

(3) Documentation of client-specific assistance and/or training rendered by the supervisor to a Companion Worker;

(4) All service logs;

(5) Records of all missed or attempted visits;

(6) Records of all complaints lodged by clients or family members/responsible parties and any actions taken; and,

(7) Evaluations from all 90 day on-site supervisory visits to the client;

(8) The Service Authorization Form notifying the DSP Agency of termination, if applicable;

(9) Initial visit for in-home services;

(10) Any other notification to Case Manager;

(11) Permission statements to release confidential information, as applicable.

b. The DSP will retain a client's file for at least five (5) years after services are terminated.

c. The DSP Agency shall comply with federal and state confidentiality laws and regulations in regard to client and employee files.

E. Rights, Responsibilities, and Service Complaints

1. The Operating Agency has the responsibility of ensuring that the DSP has fulfilled its duty of properly informing the client of all rights and responsibilities and the manner in which service complaints may be registered.

2. The DSP Agency will inform the client/responsible party of their right to lodge a complaint about the quality of Companion Service provided and/or the DSP Agency and will provide information about how to register a complaint with the Case Manager, the Operating Agency and the Alabama Medicaid Agency.

a. Complaints which are made against Companion Workers will be investigated by the DSP and documented in the client's file.

d. All complaints to be investigated will be referred to the Companion

Worker Supervisor who will take appropriate action. The proposed action to be taken will be forwarded to the Operating Agency and the Alabama Medicaid Agency for review.

e. The Companion Worker Supervisor and DSP will take the actions necessary and document the action taken in the client's and/or the employee's files, whichever is most appropriate based on the nature of the complaint. This information will be forwarded to the Operating Agency and the Alabama Medicaid Agency for review.

f. The DSP or the Companion Worker Supervisor will contact the Case Manager, Operating Agency or the Alabama Medicaid Agency by letter or telephone about any complaint and any corrective action taken.

3. The DSP must maintain documentation of all complaints, follow-up, and corrective action regarding the investigation of those complaints and documentation showing that they have complied with the requirements of this section.

G. Administrative Requirements

In addition to all conditions and requirements contained in the Scope of Service as well as in the contract with the Operating Agency, the DSP shall be required to adhere to the following stipulations:

1. The DSP shall designate an individual to serve as the administrator who shall employ qualified personnel and ensure adequate staff education, in-service training, and perform employee evaluations. This does not have to be a full-time position; however, the designated administrator will have the authority and responsibility for the direction of Companion Service for the DSP Agency. The DSP Agency shall notify the operating agency and the Alabama Medicaid Agency within three (3) working days in the event of a change in the administrator, address, telephone number, or of an extended absence of the agency administrator.

2. The DSP will maintain an organizational chart indicating the administrative control and lines of authority for the delegation of responsibility down to the "hands on" client care level staff shall be set forth in writing. This shall be readily accessible to all staff. A copy of this information shall be forwarded to the Alabama Medicaid Agency and the Operating Agency at the time the contract is implemented. Any future revisions or modifications shall be distributed to all staff of the DSP Agency and to the Alabama Medicaid Agency and the Operating Agency.

3. The DSP Agency must have written bylaws or equivalent which are defined as "a set of rules adopted by the DSP Agency for governing the agency's operations." Such bylaws or equivalent shall be readily available to staff of the DSP Agency

and shall be provided to the Operating Agency and the Alabama Medicaid Agency upon request.

4. Administrative and supervisory functions shall not be delegated to another organization.

5. A list of the members of the DSP's governing body shall be available to the Operating Agency and the Alabama Medicaid Agency upon request.

6. The DSP Agency will maintain a Policy and Procedures Manual to describe how activities will be performed in accordance with the terms of the Operating Agency contract and the waiver document. The Policy and Procedure Manual should include the organization's Emergency Plan regarding service delivery.

7. The DSP shall acquire and maintain liability insurance during the life of this contract to protect all paid and volunteer staff, including board members, from liability incurred while acting on behalf of the DSP. Upon request, the DSP shall furnish a copy of the insurance policy to the Operating Agencies and the Alabama Medicaid Agency.

8. The DSP shall conform to applicable federal, state and local health and safety rules and regulations, and have an on-going program to prevent the spread of infectious diseases among its employee (such as making substitutions for ill Companion Workers and training Companion Workers in personal hygiene and proper food handling and storage).

9. The DSP shall maintain an office, which will be open during normal business hours and staffed with qualified personnel.

10. The Direct Service Provider (DSP) shall provide its regularly scheduled holidays to the Operating Agency and the Alabama Medicaid Agency. The DSP Agency must not be closed for more than four (4) consecutive days at a time and then only if a holiday falls in conjunction with a weekend. The DSP shall also provide the regular hours of business operation. If a service is needed on a scheduled holiday, the service provider will assure that the service is rendered.

11. An annual operating budget, including all actual and anticipated revenue and expenses must be submitted to the Operating Agency and the Alabama Medicaid Agency prior to the signing of the initial contract with the Operating Agency. The budget must comply with Governmental Accepted Accounting Principles (GAAP) guidelines. The DSP Agency must maintain an annual operating budget, which shall be made available to the Operating Agency and the Alabama Medicaid Agency upon request.

H. Provider Experience

Providers of Companion Service must meet all provider qualifications prior to rendering the Companion Service.

APPENDIX B-3

KEYS AMENDMENT STANDARDS FOR BOARD AND CARE FACILITIES

KEYS AMENDMENT ASSURANCE:

The State assures that all facilities covered by section 1616(e) of the Social Security Act, in which home and community-based services will be provided are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.

APPLICABILITY OF KEYS AMENDMENT STANDARDS:

Check one:

___ Home and community-base services will not be provided in facilities covered by section 1616(e) of the Social Security Act. Therefore, no standards are provided.

_X_ A copy of the standards applicable to each type of facility identified above is maintained by the Medicaid Agency.

SECTION 1915(c) WAIVER FORMAT

APPENDIX C-Eligibility and Post-Eligibility

Appendix C-1--Eligibility

MEDICAID ELIGIBILITY GROUPS SERVED

Individuals receiving services under this waiver are eligible under the following eligibility group(s) in your State plan. The State will apply all applicable FFP limits under the plan. **(Check all that apply.)**

1. X Low income families with children as described in section 1931 of the Social Security Act.

2. X SSI recipients (SSI Criteria States and 1634 States).

3. ____ Aged, blind or disabled in 209(b) States who are eligible under 435.121 (aged, blind or disabled who meet requirements that are more restrictive than those of the SSI program).

4. ____ Optional State supplement recipients

5. ____ Optional categorically needy aged and disabled who have income at (Check one):

   a. ____ 100% of the Federal poverty level (FPL)

   b. ____% Percent of FPL which is lower than 100%.

6. X The special home and community-based waiver group under 42 CFR 435.217 (Individuals who would be eligible for Medicaid if they were in an institution, who have been determined to need home and community-based services in order to remain in the community, and who are covered under the terms of this waiver).

   Spousal impoverishment rules are used in determining eligibility for the special home and community-based waiver group at 42 CFR 435.217.

___ A. Yes _X_ B. No

Check one:

a.___ The waiver covers all individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community; or

b._X_ Only the following groups of individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community are included in this waiver: (check all that apply):

(1)_X_ A special income level equal to:

_X_ 300% of the SSI Federal benefit (FBR)

___% of FBR, which is lower than 300% (42 CFR 435.236)

$___ which is lower than 300%

(2)___ Aged, blind and disabled who meet requirements that are more restrictive than those of the SSI program. (42 CFR 435.121)

(3)___ Medically needy without spenddown in States which also provide Medicaid to recipients of SSI. (42 CFR 435.320, 435.322, and 435,324.)

(4)___ Medically needy without spenddown in 209(b) States. (42 CFR 435.330)

(5)___ Aged and disabled who have income at:

a.___ 100% of the FPL

b.___% which is lower than 100%.

(6)___ Other (Include statutory reference only to reflect additional groups included under the State plan.)

7.____ Medically needy (42 CFR 435.320, 435.322, 435.324 and 435.330)

8.____ Other (Include only statutory reference to reflect additional groups under your plan that you wish to include under this waiver.)

Appendix C-2--Post-Eligibility

GENERAL INSTRUCTIONS

ALL Home and Community-Based waiver recipients found eligible under 435.217 are subject to post-eligibility calculations.

Eligibility and post-eligibility are two separate processes with two separate calculations. Eligibility determines whether a person may be served on the waiver. Post-eligibility determines the amount (if any) by which Medicaid reduces its payment for services furnished to a particular individual. By doing so, post-eligibility determines the amount (if any) for which an individual is liable to pay for the cost of waiver services.

An eligibility determination (and periodic redetermination) must be made for each person served on the waiver.

Post-eligibility calculations are made ONLY for persons found eligible under §435.217.

Post-eligibility determinations must be made for all groups of individuals who would be eligible for Medicaid if they were in a medical institution and need home and community-based services in order to remain in the community (§435.217). For individuals whose eligibility is not determined under the spousal rules (§1924 of the Social Security Act), the State must use the regular post-eligibility rules at 435.726 and 435.735. However, for persons found eligible for Medicaid using the spousal impoverishment rules, the State has two options concerning the application of post-eligibility rules:

OPTION 1: The State may use the post-eligibility (PE) rules under 42 CFR §435.726 and §435.735 just as it does for other individuals found eligible under §435.217 or;

OPTION 2: it may use the spousal post-eligibility rules under §1924.

REGULAR POST-ELIGIBILITY RULES--§435.726 and §435.735

- The State must provide an amount for the maintenance needs of the individual. This amount must be based upon a reasonable assessment of the individual's needs in the community.

- If the individual is living with his or her spouse, or if the individual is living in the community and the spouse is living at home, the State must protect an additional amount for the spouse's maintenance. This amount is limited by the highest appropriate income standard for cash assistance, or the medically needy standard. The State may choose which standard to apply.

- If the individual's spouse is not living in the individual's home, no maintenance amount is protected for that spouse's needs.

- If other family members are living with the individual, an additional amount is protected for their needs. This amount is limited by the AFDC need standard for a family of the same size or by the appropriate medically needy standard for a family of the same size. The State may choose which standard to apply.

SPOUSAL POST-ELIGIBILITY--§1924

When a person who is eligible as a member of a 42 CFR 435.217 group has a community spouse, the State may treat the individual as if he or she is institutionalized and apply the post-eligibility rules of 1924 of the Act (protection against spousal impoverishment) instead of the post-eligibility rules under 42 CFR 435.726 and 435.735. The 1924 post-eligibility rules provide for a more generous community spouse and family allowance than the rules under 42 CFR 435.726 and 435.735. Spousal impoverishment post-eligibility rules can only be used if the State is using spousal impoverishment eligibility rules.

The spousal protection rules also provide for protecting a personal needs allowance (PNA) "described in 1902(q)(1)" for the needs of the institutionalized individual. This is an allowance which is reasonable in amount for clothing and other personal needs of the individual . . . while in an institution." For institutionalized individuals this amount could be as low as $30 per month. Unlike institutionalized individuals whose room and board are covered by Medicaid, the personal needs of the home and community-based services recipient must include a reasonable amount for food and shelter as well as for clothing. The $30 PNA is not a sufficient amount for these needs when the individual is living in the community.

Therefore, States which elect to treat home and community-based services waiver participants with community spouses under the 1924 spousal impoverishment post-eligibility rules must use as the personal needs allowance either the maintenance amount which the State has elected under 42 CFR 435.726 or 42 CFR 435.735, or an amount that the State can demonstrate is a reasonable amount to cover the individuals maintenance needs in the community.

POST ELIGIBILITY

REGULAR POST ELIGIBILITY

1.____ **SSI State.** The State is using the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services are reduced by the amount remaining after deduction the following amounts from the waiver recipients income.

A. **§435.726**--States which **do not use more restrictive** eligibility requirements than SSI.

a. Allowances for the needs of the

1. individual: (Check one):

A._X_ The following standard included under the State plan (check one):

(1)___ SSI

(2)___ Medically needy

(3)_X_ The special income level for the institutionalized

(4)___ The following percent of the Federal poverty level):___%

(5)___ Other (specify):

B.___ The following dollar amount:
$_____*

* If this amount changes, this item will be revised.

C.___ The following formula is used to determine the needs allowance:

Note: If the amount protected for waiver recipients in item 1. is **equal to, or greater than** the maximum amount of income a waiver recipient may have and be eligible under 42 CFR 435.217, **enter NA in items 2. and 3**. following.

2. spouse only (check one): **N/A**

A.___ SSI standard

B.___ Optional State supplement standard

C.___ Medically needy income standard

D.___ The following dollar amount:
$_____*

* If this amount changes, this item will be revised.

E.___ The following percentage of the following standard that is not greater than the standards above: ____% of standard.

F.___ The amount is determined using the following formula:

G.___ Not applicable (N/A)

3. Family (check one): **N/A**

A.___ AFDC need standard

B.___ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the States approved AFDC plan or the medically income standard established under 435.811 for a family of the same size.

C.___ The following dollar amount:
$____*

*If this amount changes, this item will be revised.

D.___ The following percentage of the following standard that is not greater than the standards above: %___ of standard.

E.___ The amount is determined using the following formula:

F.___ Other

G.___ Not applicable (N/A)

b. Medical and remedial care expenses specified in 42 CFR 435.726.

POST-ELIGIBILITY

REGULAR POST ELIGIBILITY

1.(b)___**209(b) State, a State that is using more restrictive eligibility requirements than SSI**. The State is using the post-eligibility rules at 42 435.735. Payment for home and community-based waiver services are reduced by the amount remaining after deduction the following amounts from the waiver recipients income.

B. **42 CFR 435.735**--States **using more restrictive** requirements than SSI.

(a) Allowances for the needs of the

1. individual: (check one):

A.___ The following standard included under the State plan (check one):

(1)___ SSI

(2)___ Medically needy

(3)___ The special income level for the institutionalized

(4)___ The following percentage of the Federal poverty level:____%

(5)___ Other (specify):

B.___ The following dollar amount:
$____*

* If this amount changes, this item will be revised.

C.___ The following formula is used to determine the amount:

Note: If the amount protected for waiver recipients in 1. is **equal to, or greater than** the maximum amount of income a waiver recipient may have and be eligible under 435.217, **enter NA in items 2. and 3**. following.

2. spouse only (check one):

A.___ The following standard under 42 CFR 435.121:

B.___ The medically needy income standard_____;

C.___ The following dollar amount: $_____*

* If this amount changes, this item will be revised.

D.___ The following percentage of the following standard that is not greater than the standards above:_____% of

E.___ The following formula is used to determine the amount:

F.___ Not applicable (N/A)

3. family (check one):

A.___ AFDC need standard

B.___ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the States approved AFDC plan or the medically income standard established under 435.811 for a family of the same size.

C.___ The following dollar amount:

$_____*

* If this amount changes, this item will be revised.

D.___ The following percentage of the following standard that is not greater than the standards above: ____% of standard.

E.___ The following formula is used to determine the amount:

F.___ Other

G.___ Not applicable (N/A)

b. Medical and remedial care expenses specified in 42 CFR 435.735.

POST ELIGIBILITY

SPOUSAL POST ELIGIBILITY

2.____ The State uses the post-eligibility rules of 1924(d) of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of home and community-based care if it determines the individual's eligibility under 1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

(A) Allowance for personal needs of the individual: (check one)

(a)___ SSI Standard

(b)___ Medically Needy Standard

(c)___ The special income level for the institutionalized

(d)___ The following percent of the Federal poverty level: ___%

(e)___ The following dollar amount $___**

**If this amount changes, this item will be revised.

(f)___ The following formula is used to determine the needs allowance:

(g)___ Other (specify):

If this amount is different from the amount used for the individuals maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individuals maintenance needs in the community.

APPENDIX D - ENTRANCE PROCEDURES AND REQUIREMENTS

APPENDIX D-1

a. EVALUATION OF LEVEL OF CARE

The agency will provide for an evaluation (and periodic reevaluations) of the need for the level(s) of care indicated in item 2 of this request, when there is a reasonable indication that individuals might need such services in the near future, but for the availability of home and community-based services.

b. QUALIFICATIONS OF INDIVIDUALS PERFORMING INITIAL EVALUATION

The educational/professional qualifications of persons performing initial evaluations of level of care for waiver participants are (Check all that apply):

___ Discharge planning team

_X_ Physician (M.D. or D.O.)

_X_ Registered Nurse, licensed in the State

_X_ Licensed Social Worker

___ Qualified Mental Retardation Professional, as defined in 42 CFR 483.430(a)

_X_ Other (Specify):

TCM Case Managers (RN or Licensed Social Worker)

The Alabama Medicaid Agency will perform a retrospective review of a 25% sample of approved waiver applications on a monthly basis to include the level of care determination of each waiver client. If it is determined, based upon concerns raised or complaints received, that more records should be reviewed, the Agency will increase the sample percentage to be reviewed.

APPENDIX D-2

a. REEVALUATIONS OF LEVEL OF CARE

Reevaluations of the level of care required by the individual will take place (at a minimum) according to the following schedule (Specify):

___ Every 3 months

___ Every 6 months

_X_ Every 12 months

_X_ Other (Specify):

More frequently if necessary due to changes in the client's condition. Monthly face-to-face case management visits are required to monitor the client's condition and evaluate the continued appropriateness of the service plan.

b. QUALIFICATIONS OF PERSONS PERFORMING REEVALUATIONS

Check one:

_X_ The educational/professional qualifications of person(s) performing reevaluations of level of care are the same as those for persons performing initial evaluations.

___ The educational/professional qualifications of persons performing reevaluations of level of care differ from those of persons performing initial evaluations. The following qualifications are met for individuals performing reevaluations of level of care (Specify):

___ Physician (M.D. or D.O.)

___ Registered Nurse, licensed in the State

___ Licensed Social Worker

___ Qualified Mental Retardation Professional, as defined in 42 CFR 483.430(a)

___ Other (Specify):

c. PROCEDURES TO ENSURE TIMELY REEVALUATIONS

The State will employ the following procedures to ensure timely reevaluations of level of care (Check all that apply):

_X_ "Tickler" file

___ Edits in computer system

_X_ Component part of case management

___ Other (Specify):

QUALIFICATIONS AND RESPONSIBILITIES OF INDIVIDUALS PERFORMING INITIAL EVALUATION

The Alabama Medicaid Agency develops the level of care criteria used to determine the individual's needs for HIV/AIDS Waiver services. The case manager will be trained by staff from the Alabama Medicaid Agency and the Operating Agency (OA) in the use of the level of care criteria.

The case manager performing the initial level of care evaluation must meet the following educational requirements:

- Bachelor of Arts degree or a Bachelor of Science degree from an accredited college or university, preferably in a human services related field, or;
- Bachelor of Arts degree or a Bachelor of Science degree from an accredited School of Social Work, or;
- Licensed as a Registered Professional Nurse (RN) by the State of Alabama Board of Nursing in accordance with *Code of Ala., 1975, Section 34-21-21*.

The individual conducting 100% review of waiver client applications to ensure medical appropriateness and make the level of care determination must meet the following certification requirements:

- Licensed as a Registered Professional Nurse (RN) by the State of Alabama Board of Nursing in accordance with *Code of Ala., 1975, Section 34-21-21*.

The Alabama Department of Public Health employs case managers who are responsible for conducting the initial level of care evaluations for individuals applying for admission and readmission to the HIV/AIDS Waiver.

The case manager will perform the initial assessment and complete the level of care evaluation. The completed assessment will be forwarded to the individual's attending physician for the completion of the medical certification. The attending physician will review and sign the medical certification on the assessment, indicating that the individual requires the institutional level of care.

The assessment, including the physician's certification, is then forwarded to the OA for review by a registered nurse who will conduct a 100% review of applications to ensure the medical appropriateness and make the level of care determination. If the OA determines that the documentation does not support the individual's need for the level of care as determined by the case manager and the attending physician, the documentation will then be forwarded to the Alabama Medicaid Agency's Long Term Care Admissions/Records Unit for nurse review and further, to the Alabama Medicaid Agency's staff physician for review. The Alabama Medicaid Agency's staff physician will make the final decision to approve or deny waiver admission based upon the documentation provided. If a denial is issued, the

recipient will receive a notice informing them of their right to an informal conference and/or a fair hearing.

The Alabama Medicaid Agency's Long Term Care Division will perform a retrospective review of a 25% sample of approved applications on a monthly basis. If it is determined, based upon concerns expressed or complaints received, that an increased percentage of applications should be reviewed, the Agency will perform an increased number of approved applications.

Appendix D-2b

Alabama Medicaid Agency

Long Term Care Division

Instructions for Completion of State of Alabama
Home and Community Based Services (HCBS) Program
Assessment Form

HCBS Page 1. Instructions

1. Indicate the type of application that is being submitted.

2. Indicate the date on which the form is being completed.

3. In the space provided, only supply information if a re-determination is being completed. Enter the ending date that appears on the most current LTC 2 notification. For example, if the dates given are January 5, 2002 through January 31, 2003, the date that should be entered is January 31, 2003.

4. Enter the current case manager's name.

5. Enter the county/area agency/and, or regional office name. For example, SARCOA (South Alabama Regional Council on Aging).

6. Enter agency phone number. This field should reflect the current case manager's phone number.

7. Enter the Case Number. This field may be left blank.

8. Enter the Medicaid number exactly as it appears on the Medicaid card. Financial eligibility should be verified and if the application is for institutional deeming or for 300% of SSI, then the financial application should be submitted to the Alabama Medicaid District Office for processing.

9. Enter the prior control number that has been assigned by the Operating Agency (OA). This number should always be a nine-digit number.

10. Enter the client's name exactly as it appears on the Medicaid card.

11. Enter the resident address of the client or the emergency address. This should never be a Post Office Box number.

12. Enter the name of the city in which the client resides.

13. Enter the zip code of the address recorded in #12.

14. When providing directions begin with a central point of reference, such as the office location. Be specific and include landmarks and distances. For example, go north on 23rd Street from the Area Commission on Aging Office for 2 blocks. You will pass First Baptist Church on your right. Turn onto 3rd Avenue immediately past the church. Go to the 4th house on the left. House is tan with vinyl siding.

15. Enter the client's telephone number if applicable. In the event there is no phone, obtain a phone number of someone whom you may relay messages.

16. Enter the client's date of birth to include month, day and year.

17. Check the applicable box related to marital status.

18. Check the applicable box of the client's race.

19. Check the applicable box of the client's sex.

20. Check the applicable box of whether the client lives alone.

21. Enter the name of the client's primary care physician.

22. Enter the physician's address.

23. Enter the city for the physician's address.

24. Enter the state for the physician's address.

25. Enter the zip code for the physician's address.

26. Enter the phone number for the physician.

27. Enter the name of a person to contact in case of an emergency.

28. Enter the address of the emergency contact.

29. Enter the city of residence of the emergency contact.

30. Enter the phone number of the emergency contact.

31. Screen and indicate whether the person has a third party payor source.

32. Screen for the indicator of Medicare for the client. If the client has Medicare, then the case manager will screen for both Part A and Part B. Note: Part A is associated with hospital coverage and Part B is associated with outpatient, DME, physician office visits, etc.

33. Indicate the present history of the client's home situation by checking the appropriate box. Has the client been maintained in the home with care, without care? Did the client come from a hospital or nursing home?

34. This section should be completed based upon the findings of the case manager of the home environment.

35. Check the appropriate box of the referral source of the client. If "other" is indicated, write in the referral source. The referral source could be a home health nurse, DHR worker, etc.

36. Indicate the current living situation of the client.

37. Record the name of the primary caregiver and their relationship to the client. Check the box that is applicable.

38. List any other names of members of the client's household and their relationships to the client.

HCBS Page 2. Instructions

1. Enter the client's name exactly as it appears on the Medicaid card.

2. Enter the client's Medicaid number exactly as it appears on the Medicaid card.

3. An assessment of the recipient's activities of daily living should be done by the case manager. Check the boxes that apply to the recipient and include the name of the person and/or agency that is meeting these needs. Include the phone number in the appropriate column for the person providing these services.

4. The assessment should include a review of any medical or assistive devices that may be present and used or needed. Check the column that is applicable.

5. The assessment should include a history related to elimination problems. If yes is checked, the boxes that apply should also be checked. If no is checked, there is no need to make any other checks.

6. The case manager should review names of all medications. All non-prescription drugs taken by the client should be entered in this section.

7. A history related to the client's mental status should be obtained. Select any boxes that are specific to the client by placing a check in the box.

8. A history of any sensory impairments should be obtained during the screening process by the case manager. The applicable box for the client should then be checked.

9. Indicate the appropriate income category of the client. If the client is in the income category for 300% of SSI or institutional deeming, the application should be forwarded to the Alabama Medicaid Agency's District Office for processing.

10. Indicate all agencies that provided services in the home or the community within the past 3 months.

11. The comment section should include a narrative summary by the case manager that helps describe the needs of the client for home and community based services.

HCBS Page 3. Instructions

1. Enter the agency name, address and phone number for mailing purposes or any questions that might arise by the physician when this form is routed to them for review and signature.

2. Enter the name of the recipient just as it appears on the Medicaid card.

3. Complete this section by checking the appropriate box if the client has a diagnosis of MR, MI, or DD.

4. This space authorizes the release of information for determination of eligibility for services. This space should be signed and dated by the client or their legal representative. If the client is unable to sign and there is no legal representative available, then an "**X"** marked by the patient is acceptable, but must be witnessed by an additional person.

5. Enter the client's 13-digit Medicaid number.

6. Enter the client's date of birth.

7. Enter the date that the client signature is obtained.

8. The case manager should check the appropriate box if there is a history of a psychological or psychiatric problem and attach a psych summary.

9. This space indicates that the recipient has been given a choice between nursing home care and home and community based services. Once the client signs, this indicates that they have chosen home and community services. The same information as explained in # 4 above related to signatures is also applicable here.

10. Indicate all current diagnoses by checking those that are applicable.

11. The required services section contains the current Medicaid medical criteria for admission into programs. All new and re-admissions must meet (2) criteria. Re-determinations must meet one criterion. Supporting documentation of these criteria must be present in the application.

12. Any additional diagnoses not previously indicated should be documented in this column.

13. Check the appropriate box. If yes is checked in this section, then the type of special or therapeutic diet the client is receiving should be noted under the section labeled “Describe”. Example: Glucerna per g-tube bolus feedings 4 times per day, 1800 Calorie ADA diet, etc.

14. The recipient should be screened for allergies. Check the appropriate box. If a history of allergies is present then the type of allergy, or name of medication that produces allergy symptoms should be listed in the column labeled describe.

15. The patient should be screened for any history of communicable diseases and the appropriate box checked.

16. The physician certification must indicate that the client requires home and community based services. The statement on the form now states “I certify that without Home and Community Based Services that this patient would be at risk for nursing facility care.”

17. The physician must sign this statement. A stamp is not acceptable. A certified registered nurse practitioner’s (CRNP’s) signature is not acceptable.

18. The physician’s signature must be dated.

19. The address of the physician signing this form should be recorded.

20. The city of the physician’s address should be recorded.

21. Prescription medications to include frequency should be listed in this column.

22. The telephone number of the physician signing this form should be recorded.

APPENDIX D-3

a. MAINTENANCE OF RECORDS

1. Records of evaluations and reevaluations of level of care will be maintained in the following location(s) (Check all that apply):

___ By the Medicaid Agency in its central office

___ By the Medicaid Agency in district/local offices

_X_ By the agency designated in Appendix A as having primary authority for the daily operations of the waiver program

_X_ By the case managers

___ By the persons or agencies designated as responsible for the performance of evaluations and reevaluations

_X_ By service providers

___ Other (Specify):

Client records will be made readily available for review by the Alabama Medicaid Agency upon request.

2. Written documentation of all evaluations and reevaluations will be maintained as described in this Appendix for a minimum period of 3 years.

b. COPIES OF FORMS AND CRITERIA FOR EVALUATION / ASSESSMENT

A copy of the written assessment instrument(s) to be used in the evaluation and reevaluation of an individual's need for a level of care indicated in item 2 of this request is attached to this Appendix.

For persons diverted rather than deinstitutionalized, the State's evaluation process must provide for a more detailed description of their evaluation and screening procedures for individuals to ensure that waiver services will be limited to persons who would otherwise receive the level of care specified in item 2 of this request.

Check one:

_X_ The process for evaluating and screening diverted individuals is the same as that used for deinstitutionalized persons.

___ The process for evaluating and screening diverted individuals differs from that used for deinstitutionalized persons. Attached is a description of the process used for evaluating and screening diverted individuals.

The level of care (LOC) form used by the State, as incorporated in this waiver proposal, is the form that is utilized for all other approved 1915(c) home and community based service (HCBS) waivers. This form differs from the form used for nursing facility placement, in that it requires a complete assessment of the client's home environment. However, the medical LOC criteria used to determine admission to the HIV/AIDS waiver is the same medical criteria used to determine admission to nursing facilities.

APPENDIX D-4

a. FREEDOM OF CHOICE AND FAIR HEARING

1. When an individual is determined to be likely to require a level of care indicated in item 2 of this request, the individual or his or her legal representative will be:

   a. informed of any feasible alternatives under the waiver; and

   b. given the choice of either institutional or home and community-based services.

2. The agency will provide an opportunity for a fair hearing under 42 CFR Part 431, subpart E, to individuals who are not given the choice of home or community-based services as an alternative to the institutional care indicated in item 2 of this request or who are denied the service(s) of their choice, or the provider(s) of their choice.

3. The following are attached to this Appendix:

   a. A copy of the form(s) used to document freedom of choice and to offer a fair hearing;

   b. A description of the agency's procedure(s) for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver;

   c. A description of the State's procedures for allowing individuals to choose either institutional or home and community-based services; and

   d. A description of how the individual (or legal representative) is offered the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E.

b. FREEDOM OF CHOICE DOCUMENTATION

Specify where copies of this form are maintained:

The Certificate of Choice Form, attached as D-4a, is maintained in the client's file located at the service coordination agency providing AIDS Waiver case management, and the Direct Service Provider Agencies. Freedom of Choice documentation will be readily available for review by the Alabama Medicaid Agency upon request.

CERTIFICATE OF CHOICE

Title XIX Home and Community Based Service Waiver for the HIV/AIDS Waiver

*Under the provisions of Alabama's HIV/AIDS Waiver, in accordance with the Social Security Act of 1965, as amended, applicants for waiver services or a designated responsible party with authority to act on the applicant's behalf will, when the applicant is found eligible for waiver services, be offered the alternative of home and community based services or institutional services.

Program: _____

Client's Name: _____

Client's Medicaid Number: _____

I have been given a choice between Community Services and nursing home care and I have chosen Community Services.

Signed: _____
(Recipient)

Witness: _____

Date: _____

Witness: _____

Signed: _____
(Patient Representative)

_____
(Relationship)

Date: _____

DISSATISFACTON OF SERVICES

REQUEST CONFERENCE OR REVIEW OF CASE

A person may notify the Alabama Medicaid Agency giving the reason for the dissatisfaction and ask for either a conference or a review of the case by the Alabama Medicaid Agency. At the conference, the person may present the information or may be represented by a friend, relative, attorney or other spokesperson of his/her choice.

REQUEST A FAIR HEARING

In accordance with 42 C.F.R. 431.211, the individual must receive at least a ten (10) day advance notice of the termination of services, reduction of services, or change in the type of services to be provided under the waiver. If the individual is dissatisfied with the action taken, the Alabama Medicaid Agency will provide an opportunity for an informal conference or review of their case by the Alabama Medicaid Agency. At the conference, the person may present the information or may be represented by a friend, relative, attorney, or other spokesperson of his/her choice.

The Alabama Medicaid Agency will provide an opportunity for a fair hearing under 42 C.F.R. 431 Subpart E for individuals who are still dissatisfied after the above procedure has been completed. A written request for a hearing must be filed within thirty (30) days following the action with which the individual is dissatisfied. The individual or his/her legally appointed representative or other authorized person must request the hearing and give a correct mailing address for receipt of information. If the request for the hearing is made by someone other than the person who wishes to appeal, the person requesting the hearing must make a definite statement that they have been authorized to do so by the person for whom the hearing is being requested. Information about the hearing date and the location of the hearing will be provided to the individual. The hearing will be arranged at a place convenient to the person. If the person is satisfied before the hearing and wants to withdraw the request for the hearing, the individual or his/her legally appointed representative or other authorized person should write the Alabama Medicaid Agency of his/her desire to withdraw the request and give the reason for withdrawing.

The Alabama Medicaid Agency need not grant a request for a hearing if the sole issue is a federal or state law or policy which requires an automatic change adversely affecting some or all recipients.

When benefits are terminated, they can be continued if a hearing request is received within ten (10) days following the effective date of termination. If benefits are continued pending the outcome of the hearing and the Hearing Officer decides that termination was proper, Alabama Medicaid Agency may recover from the terminated recipient or sponsor, the costs of all benefits paid after the initial termination date.

MEDICAID BENEFICIARY SERVICES POLICIES AND PROCEDURES IN COMPLIANCE WITH CIVIL RIGHTTS ACT OF 1964 AND SECTION 504 OF THE REHABILITATION ACT OF 1973, THE AGE DISCRIMINATION IN EMPLOYMENT ACT AND THE AMERICANS WITH DISABILITIES ACT OF 1990

I have reviewed and been given a copy of my rights to a Medicaid review of the case and/or a Fair Hearing.

_____ _____

(Recipient and/or Legal Representative) (Date)

APPENDIX E - PLAN OF CARE

APPENDIX E-1

a. PLAN OF CARE DEVELOPMENT

1. The following individuals are responsible for the preparation of the plans of care:

_X_ Registered nurse, licensed to practice in the State

___ Licensed practical or vocational nurse, acting within the scope of practice under State law

_X_ Physician (M.D. or D.O.) licensed to practice in the State

___ Social Worker (qualifications attached to this Appendix)

_X_ Case Manager

___ Other (specify):

2. Copies of written plans of care will be maintained for a minimum period of 3 years. Specify each location where copies of the plans of care will be maintained.

___ At the Medicaid Agency central office

___ At the Medicaid Agency county/regional offices

_X_ By case managers

_X_ By the agency specified in Appendix A

___ By consumers

_X_ Other (specify): Direct Service Provider (DSP) Agency

The Alabama Medicaid Agency will perform a retrospective review of a 25% sample of approved waiver applications on a monthly basis to include Plans of Care of each waiver client. If it is determined, based upon concerns raised or complaints received, that more records should be reviewed, the Agency will increase the sample percentage to be reviewed.

3. The plan of care is the fundamental tool by which the State will ensure the health and welfare of the individuals served under this waiver. As such, it will be subject to periodic review and update. These reviews will take place to determine the appropriateness and adequacy of the services, and to ensure that the services furnished are consistent with the nature and severity of the individual's disability. The minimum schedule under which these reviews will occur is:

___ Every 3 months

___ Every 6 months

_X_ Every 12 months

_X_ Other (specify):

More frequently if necessary based on changes in the client's condition. Monthly face-to-face case management visits are required to monitor the client's condition and to evaluate the continued appropriateness of the service plan.

Alabama Medicaid Agency

Long Term Care Division

Instructions for Completion of State of Alabama Home and Community Based Services (HCBS) Program Assessment Form

HCBS Page 4. Instructions – Plan of Care

1. Print or type the client's name. The space below is to be utilized for the client's signature indicating that he/she is in agreement with the plan of care.

2. Enter the client's 13-digit Medicaid number.

3. Enter the case manager's name. The case manager must sign on the line below his/her printed name indicating that the plan of care was reviewed with the client.

4. Enter the current date. The space below should contain the date that the client reviewed and signed the plan of care.

5. Indicate the objective you wish to obtain of each waiver service listed.

6. List the exact service to be provided.

7. Enter the name of the provider of each service.

8. Enter the frequency of each service listed. The frequency must be specific. For example, 2 hours, 2 times per week for Homemaker service.

9. Enter the date that the service will begin.

10. Enter the ending date only if the service is stopped of if the frequency changes. For example: The homemaker hours are 2 hours, 2 times per week, and the client is admitted to the hospital. The client is discharged from the hospital. The re-assessment completed by the case manager indicates a need to increase the service provision to 2 hours, 3 times per week. There would be an end date listed for the initial homemaker service and the new homemaker service hours would be listed on the care plan with the new start of care date.

11. Enter the objective of the non-waiver service(s).

12. Enter the name of the non-waiver service(s).

13. Enter the name of the provider of non-waiver service(s).

14. Enter the frequency of the non-waiver service(s).

15. Enter the start date of the non-waiver service(s).

16. Enter the ending date of the non-waiver service(s).

17. Enter the date that the case manager completes the 60-day review.

APPENDIX E-2

a. MEDICAID AGENCY APPROVAL

The following is a description of the process by which the plan of care is made subject to the approval of the Medicaid Agency: **See Attachment Appendix E-2a**

b. STATUTORY REQUIREMENTS AND COPY OF PLAN OF CARE

1. The plan of care will contain, at a minimum, the type of services to be furnished, the amount, the frequency and duration of each service, and the type of provider to furnish each service.

2. A copy of the plan of care form to be utilized in this waiver is attached to this Appendix.

PLAN OF CARE DEVELOPMENT

The following is a description of the process by which the Plan of Care is developed.

- The Alabama Medicaid Agency develops the level of care criteria and the Plan of Care (POC) document.

- The Alabama Medicaid Agency along with the Operating Agency (OA) provides case management training related to the assessment of the individual and the method of developing the Plan of Care based on specific individual's needs.

- The POC will include the types of service, the number of units of service, the frequency and duration of each service, and the provider of each service.

- The OA will designate a registered nurse to review and approve both the Plan of Care and the level of care assessment prior to initiating service delivery. The OA nurse will ensure that all federal and state requirements are met prior to initiating service delivery.

- The Alabama Medicaid Agency's Long Term Care Division will perform a retrospective review of a 25% sample of approved applications to include the POC.

- The Alabama Medicaid Agency's, Long Term Care Quality Assurance Unit will conduct onsite reviews of direct service providers, including the POC and the client assessment, to ensure compliance with the level of care and delivery of services included on the POC.

APPENDIX F - AUDIT TRAIL

a. DESCRIPTION OF PROCESS

1. As required by sections 1905(a) and 1902(a)(32) of the Social Security Act, payments will be made by the Medicaid agency directly to the providers of waiver and State plan services.

2. As required by section 1902(a)(27) of the Social Security Act, there will be a provider agreement between the Medicaid agency and each provider of services under the waiver.

3. Method of payments (check one):

__X__ Payments for all waiver and other State plan services will be made through an approved Medicaid Management Information System (MMIS).

____ Payments for some, but not all, waiver and State plan services will be made through an approved MMIS. A description of the process by which the State will maintain an audit trail for all State and Federal funds expended, and under which payments will be made to providers is attached to this Appendix.

____ Payment for waiver services will not be made through an approved MMIS. A description of the process by which payments are made is attached to this Appendix, with a description of the process by which the State will maintain an audit trail for all State and Federal funds expended.

____ Other (Describe in detail):

b. BILLING AND PROCESS AND RECORDS RETENTION

1. Attached is a description of the billing process. This includes a description of the mechanism in place to assure that all claims for payment of waiver services are made only:

   a. When the individual was eligible for Medicaid waiver payment on the date of service;

   b. When the service was included in the approved plan of care;

   c. In the case of supported employment, prevocational or educational services included as part of habilitation services, when the individual was eligible to receive the services and the services were not available to the individual through a program funded under section 602(16) or (17) of the Individuals with Disabilities Education Act (P.L. 94-142) or section 110 of the Rehabilitation Act of 1973.

      ____ Yes

      __X__ No. These services are not included in this waiver.

2. The following is a description of all records maintained in connection with an audit trail. Check one:

   __X__ All claims are processed through an approved MMIS.

   ____ MMIS is not used to process all claims. Attached is a description of records maintained with an indication of where they are to be found.

3. Records documenting the audit trail will be maintained by the Medicaid agency, the agency specified in Appendix A (if applicable), and providers of waiver services for a minimum period of 3 years.

c. PAYMENT ARRANGEMENTS

1. Check all that apply:

__X__ The Medicaid Agency will make payments directly to providers of waiver services.

__X__ The Medicaid Agency will pay providers through the same fiscal agent used in the rest of the Medicaid program.

____ The Medicaid Agency will pay providers through the use of a limited fiscal agent who functions only to pay waiver claims.

__X__ Providers may *voluntarily* reassign their right to direct payments to the following governmental agencies (specify):

Alabama Department of Public Health

Providers who choose not to voluntarily reassign their right to direct payments will **not** be required to do so. Direct payments will be made using the following method:

A detailed description of the billing process to be utilized for the proposed waiver is attached as Appendix F-1.

2. Interagency agreement(s) reflecting the above arrangements are on file at the Medicaid agency.

DESCRIPTION OF THE BILLING PROCESS

(1) For dates of service beginning January 1, 2003 (FY-04) and after, payments made by Medicaid to providers will be on a fee-for-service basis. Each covered service is identified on a claim by a procedure code.

(2) For each recipient, the claim will allow span billing for a period up to one month. There may be multiple claims in a month; however no single claim can cover services performed in different months. For example, claims with dates of service of 1/15/03 to 2/15/03 would not be allowed. If the submitted claim covers dates of service where part, or all of which were covered in a previously paid claim, the claim will be rejected.

(3) Payment will be based on the number of units of service reported on the claim for each procedure code.

(4) The basis for the fees will generally be based on audited past performance with consideration being given to the health care index and renegotiated contracts. The interim fees may also be changed if a provider can show that an unavoidable event(s) has caused a substantial increase or decrease in the provider's cost.

(5) The Operating Agencies (OA), as specified in the approved waiver document, are governmental agencies and will receive actual cost for services rendered. The actual fee for service may differ among OAs. OAs have 120 days from the end of the waiver year to submit claims for services rendered. No claims for services in any given waiver year will be processed beyond 120 days after the end of that waiver year.

(6) Accounting for actual cost and units of services provided during a waiver year must be captured on HCFA Form 372. The following accounting definitions will be used to capture reporting data, and the audited figures used in establishing new interim fees:

(a) A waiver year consists of twelve consecutive months starting with the approval date specified in the approved waiver document.

(b) An expenditure occurs when cash or its equivalent is paid in a quarter by a state agency for waiver benefits. For a public/governmental provider, the expenditure is made whenever it is paid or recorded, whichever is earlier. Non-case payments, such as depreciation, occur when transactions are recorded by the state agency.

(c) The services provided by an operating agency is reported and paid by dates of service. Thus, all services provided during the twelve months of the waiver year will be attributed to that year.

(7) The provider's costs shall be divided between benefit and administrative cost. The benefit portion is included in the fee for service. The administrative portion will be divided in twelve equal amounts and will be invoiced by the provider directly to the Alabama Medicaid Agency. Since administration is relatively fixed, it will not be a rate per claim, but a set monthly payment. As each waiver year is audited, this cost, like the benefit cost, will be determined and lump sum settlement will be made to adjust that year's payments to actual cost.

(8) The Alabama Medicaid Agency's Provider Audit/Reimbursement Division maintains the year-end cost reports submitted by the Alabama Department of Public Health (ADPH).

(9) Providers must retain records that fully disclose the extent and cost of services provided to the eligible recipients for a five (5) year period. These records must be accessible to the Alabama Medicaid Agency and appropriate state and federal officials.

(10) There must be a clear differentiation between waiver services and non-waiver services. There must be a clear audit trail from the point a service is provided through billing and reimbursement. The OA, Alabama Medicaid Agency and Centers for Medicare and Medicaid Services (CMS) must be able to review the Plan of Care to verify the exact service and number of units provided, the date the service was rendered, and the direct service provider for each recipient. There must be a detailed explanation of how waiver services are segregated from ineligible waiver costs.

APPENDIX G - FINANCIAL DOCUMENTATION

APPENDIX G-1
COMPOSITE OVERVIEW
COST NEUTRALITY FORMULA

INSTRUCTIONS: Complete one copy of this Appendix for each level of care in the waiver. If there is more than one level (e.g. hospital and nursing facility), complete a Appendix reflecting the weighted average of each formula value and the total number of unduplicated individuals served.

LEVEL OF CARE: NF

YEAR	FACTOR D	FACTOR D'	FACTOR G	FACTOR G'
1	$18,384	$8,035	$27,498	$16,670
2	$19,007	$8,308	$28,433	$17,237
3	$19,654	$8,590	$29,400	$17,823
4				
5				

FACTOR C: NUMBER OF UNDUPLICATED INDIVIDUALS SERVED

YEAR	UNDUPLICATED INDIVIDUALS
1	150
2	150
3	150
4	
5	

EXPLANATION OF FACTOR C:

Check one:

____ The State will make waiver services available to individuals in the target group up to the number indicated as factor C for the waiver year.

_X_ The State will make waiver services available to individuals in the target group up to the lesser of the number of individuals indicated as factor C for the waiver year, or the number authorized by the State legislature for that time period.

The State will inform HCFA in writing of any limit which is less than factor C for that waiver year.

APPENDIX G-2
METHODOLOGY FOR DERIVATION OF FORMULA VALUES

FACTOR D

LOC: ____NF_____

The July 25, 1994 final regulation defines Factor D as:

> "The estimated annual average per capita Medicaid cost for home and community-based services for individuals in the waiver program."

The demonstration of Factor D estimates is on the following page.

APPENDIX G-2
FACTOR D
LOC: **NF**

Demonstration of Factor D estimates:

Waiver Year 1___ 2___ 3___ 4___ 5

Waiver Service Column A	#Unduplicated Recipients (Users) Column B	Avg. # Annual Units Per User Column C	Average Unit Cost Column D	Total Column E
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				

GRAND TOTAL (SUM OF COLUMN E):

TOTAL ESTIMATED UNDUPLICATED RECIPIENTS (FACTOR C)

DIVIDE TOTAL BY NUMBER OF RECIPIENTS (FACTOR D)

AVERAGE LENGTH OF STAY:

APPENDIX G-3
METHODS USED TO EXCLUDE PAYMENTS FOR ROOM AND BOARD

The purpose of this Appendix is to demonstrate that Medicaid does not pay the cost of room and board furnished to an individual under the waiver. NA

A. The following service(s), other than respite care*, are furnished in residential settings other than the natural home of the individual(e.g., foster homes, group homes, supervised living arrangements, assisted living facilities, personal care homes, or other types of congregate living arrangements). (Specify):

*NOTE: FFP may be claimed for the cost of room and board when provided as part of respite care in a Medicaid certified NF or ICF/MR, or when it is provided in a foster home or community residential facility that meets State standards specified in this waiver.)

B. The following service(s) are furnished in the home of a paid caregiver. (Specify):

Attached is an explanation of the method used by the State to exclude Medicaid payment for room and board.

APPENDIX G-4
METHODS USED TO MAKE PAYMENT FOR RENT AND FOOD EXPENSES OF AN UNRELATED LIVE-IN CAREGIVER

Check one:

__X__ The State will not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who lives with the individual(s) served on the waiver.

____ The State will reimburse for the additional costs of rent and food attributable to an unrelated live-in personal caregiver who lives in the home or residence of the individual served on the waiver. The service cost of the live-in personal caregiver and the costs attributable to rent and food are reflected separately in the computation of factor D (cost of waiver services) in Appendix G-2 of this waiver request.

Attached is an explanation of the method used by the State to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver.

APPENDIX G-5

FACTOR D'

LOC: NF

NOTICE: On July 25, 1994, HCFA published regulations which changed the definition of factor D'. The new definition is:

> "The estimated annual average per capita Medicaid cost for all other services provided to individuals in the waiver program."

Include in Factor D' the following:

> The cost of all State plan services (including home health, personal care and adult day health care) furnished in addition to waiver services WHILE THE INDIVIDUAL WAS ON THE WAIVER.
>
> The cost of short-term institutionalization (hospitalization, NF, or ICF/MR) which began AFTER the person's first day of waiver services and ended BEFORE the end of the waiver year IF the person returned to the waiver.

Do NOT include the following in the calculation of Factor D':

> If the person did NOT return to the waiver following institutionalization, do NOT include the costs of institutional care.
>
> Do NOT include institutional costs incurred BEFORE the person is first served under the waiver in this waiver year.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor D'.

APPENDIX G-5

FACTOR D' (cont.)

LOC: ___NF

Factor D' is computed as follows (check one):

____ Based on HCFA Form 2082 (relevant pages attached).

____ Based on HCFA Form 372 for years ____ of waiver # ____, which serves a similar target population.

____ Based on a statistically valid sample of plans of care for individuals with the disease or condition specified in item 3 of this request.

__X__ Other (specify): The computation for Factor D' was obtained from paid claims data derived from a query, which included all Medicaid costs for recipients with an HIV/AIDS and related illness diagnosis, who lived in the community during fiscal year 2001. An inflation factor of 3.4 percent was applied to each subsequent year of the initial waiver request.

APPENDIX G-6

FACTOR G

LOC: _____NF_____

The July 25, 1994 final regulation defines Factor G as:

> "The estimated annual average per capita Medicaid cost for hospital, NF, or ICF/MR care that would be incurred for individuals served in the waiver, were the waiver not granted."

Provide data ONLY for the level(s) of care indicated in item 2 of this waiver request.

Factor G is computed as follows:

____ Based on institutional cost trends shown by HCFA Form 2082 (relevant pages attached). Attached is an explanation of any adjustments made to these numbers.

____ Based on trends shown by HCFA Form 372 for years ____of waiver #____, which reflect costs for an institutionalized population at this LOC. Attached is an explanation of any adjustments made to these numbers.

____ Based on actual case histories of individuals institutionalized with this disease or condition at this LOC. Documentation attached.

____ Based on State DRGs for the disease(s) or condition(s) indicated in item 3 of this request, plus outlier days. Descriptions, computations, and an explanation of any adjustments are attached to this Appendix.

__X__ Other (specify): The computation for Factor G was obtained from paid claims data derived from a query, which included all Medicaid institutional costs for recipients with an HIV/AIDS and related illness diagnosis, who resided a nursing facility during fiscal year 2001. An inflation factor of 3.4 percent was applied to each subsequent year of the initial waiver request.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor G.

APPENDIX G-7

FACTOR G'

LOC: NF

The July 25, 1994 final regulation defines Factor G' as:

> "The estimated annual average per capita Medicaid costs for all services other than those included in Factor G for individuals served in the waiver, were the waiver not granted.

Include in Factor G' the following:

> The cost of all State plan services furnished WHILE THE INDIVIDUAL WAS INSTITUTIONALIZED.
>
> The cost of short-term hospitalization (furnished with the expectation that the person would return to the institution) which began AFTER the person's first day of institutional services.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor G'.

APPENDIX G-7

FACTOR G'

LOC: _____NF_____

Factor G' is computed as follows (check one):

____ Based on HCFA Form 2082 (relevant pages attached).

____ Based on HCFA Form 372 for years ____ of waiver # ____, which serves a similar target population.

____ Based on a statistically valid sample of plans of care for individuals with the disease or condition specified in item 3 of this request.

__X__ Other (specify): The computation for Factor G' was obtained from paid claims data derived from a query, which included Medicaid acute care costs (e.g. physician office visits, inpatient hospital care, outpatient hospital care, etc.) provided for recipients with an HIV/AIDS and related illness diagnosis, who resided in a nursing facility during fiscal year 2001. An inflation factor of 3.4 percent was applied to each subsequent year of the initial waiver request.

APPENDIX G-8

DEMONSTRATION OF COST NEUTRALITY

LOC: NF

YEAR 1

FACTOR D:	$18,384		FACTOR G:	$27,498
FACTOR D':	$8,035		FACTOR G':	$16,670
TOTAL:	$26,419	≤	TOTAL:	$44,168

YEAR 2

FACTOR D:	$19,007		FACTOR G:	$28,433
FACTOR D':	$8,308		FACTOR G':	$17,237
TOTAL:	$27,315	≤	TOTAL:	$45,670

YEAR 3

FACTOR D:	$19,654		FACTOR G:	$29,400
FACTOR D':	$8,590		FACTOR G':	$17,823
TOTAL:	$28,244	≤	TOTAL:	$47,223

APPENDIX G-8

DEMONSTRATION OF COST NEUTRALITY (cont.)

LOC:

YEAR 4

FACTOR D:	____		FACTOR G:
FACTOR D':	____		FACTOR G':
TOTAL:	____	≤	TOTAL:

YEAR 5

FACTOR D:	____		FACTOR G:
FACTOR D':	____		FACTOR G':
TOTAL:	____	≤	TOTAL:

DOCUMENTATION TO SUPPORT FACTORS G, G' AND D'

The base data for G and G' was obtained from a report generated by the Alabama Medicaid Agency to identify Medicaid recipients residing in a nursing facility with a diagnosis of HIV/AIDS and/or related illness for fiscal year 2001 (October 1, 2000– September 30, 2001).

The recipients who were identified were used for the purposes of calculating Medicaid institutional costs. Although 61 recipients were yielded from query results as having a nursing facility segment, for the purposes of determining an accurate amount of Medicaid institutional costs the State will use an identified 7 recipients who resided in the facility for the entire fiscal year. These 7 recipients had claims during FY '01 for which Medicaid reimbursement was made for nursing facility claims submitted. The total Medicaid reimbursement was $192,487 for an average cost of $27,498 per recipient (Factor G).

The Medicaid acute care costs for paid claims for the 7 identified recipients totaled $116,688 for an average cost of $16,670 per recipient (Factor G').

The data for Factor D' was based on identified Medicaid recipients living in the community with a diagnosis of HIV/AIDS and related illness during the 2001 fiscal year. The 1,413 recipients identified in the query totaled $11,353,325 for an average Medicaid cost of $8,035 per recipient.

An inflation factor of 3.4%, derived from the Consumer Price Index – Medical Care Component, was added to each subsequent year of the initial waiver request.

Below, please find each portion of the analysis and projections derived for Factors G, G' and D'.

FACTOR G DATA:

Based on FY '01 Medicaid paid claims data

Number of Recipients Institutionalized	Medicaid Institutional Costs
7	$192,487

Average Medicaid institutional cost per recipient:
$192,487 / 7 = $27,498

Inflation Factor (3.4%) Calculation for Waiver Years 2 and 3:

Waiver Year 1: $27,498

Waiver Year 2: $27,498 (3.4%) = $28,433

Waiver Year 3: $28,433 (3.4%) = $29,400

FACTOR G' DATA

Based on FY '01 Medicaid paid claims data

Number of Recipients Institutionalized	Medicaid Acute Care Costs
7	$116,688

Average Medicaid acute care cost per recipient:
$116,688 / 7 = $16,670

Inflation Factor (3.4%) Calculation for Waiver Years 2 and 3:

Waiver Year 1: $16,670

Waiver Year 2: $16,670 (3.4%) = $17,237

Waiver Year 3: $17,237 (3.4%) = $17,823

FACTOR D' DATA

Based on FY '01 Medicaid paid claims data

Number of Recipients in Community	Medicaid Acute Care Costs
1,413	$11,353,325

Average Medicaid acute care cost per recipient:
$11,353,325 / 1,413 = $8,035

Inflation Factor (3.4%) Calculation for Waiver Years 2 and 3:

Waiver Year 1: $8,035

Waiver Year 2: $8,035 (3.4%) = $8,308

Waiver Year 3: $8,308 (3.4%) = $8,590